Health Care Financing Administration Rulings

On Medicare, Medicaid,
Professional Standards Review
and Related Matters

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Foreword

Programs of the Health Care Financing Administration—including Medicare, Medicaid, and Professional Standards Review Organizations—affect millions of people throughout the United States. To fully understand these programs, it is necessary to have access to the administrative instructions and manuals which guide staffs of Federal and State agencies and HCFA contractors in implementing the programs. In addition, official public rulings of the agency show how regulations are interpreted and applied.

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HCFA Rulings should be of use to Medicare and Medicaid beneficiaries, Federal and State employees who administer ths programs, intermediaries, carriers, providers of services under the programs, other contractors to HCFA, attorneys, court and hearing personnel, and interested members of the public.

Howard Newman
Administrator
Health Care Financing Administration

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42 CFR 405.419 HCFAR 79–63c

A provider claims the Medicare provision disallowing reimbursement for interest payments made to a related organization (42 CFR § 405.419 (b)(3)(ii)) embodies an unconstitutional, irrebuttable presumption that its loans were illegitimate, unnecessary or at excessive interest. *Held,* the Secretary has authority to decide that administrative resources should not be expended upon inquiring into the business necessity of every interest-bearing transaction between large, complex, related organizations. Because denying reimbursement for interest payments made to a related organization does not lack either a rational justification or a reasonable basis, there is no constitutional violation.

ESCHBACH, DISTRICT JUDGE:

Plaintiff contends that a Medicare regulation constitutes an unconstitutional irrebuttable presumption or violates the equal protection and due process clauses of the fifth amendment. For the reasons set forth below, the motion of defendant will be granted and the motion of plaintiff will be denied.

I. THE IRREBUTTABLE PRESUMPTION ARGUMENT

A. The Regulation and its Purpose

Plaintiff Caylor-Nickel Hospital, Inc. (Caylor-Nickel) is a not-for-profit hospital, certified as a Medicare provider and therefore entitled to reimbursement by the federal government for certain costs. 42 C.F.R. § 405.419(b)(3)(ii) denies reimbursement of interest if the lender is related "through control or ownership, or personal relationship to the borrowing organization." Caylor-Nickel was denied reimbursement for interest on four separate debts in 1974 and 1975 on the ground that Caylor-Nickel was related to the persons or corporations to which the interest was paid. Denial was made first by a fiscal intermediary (Mutual Hospital Insurance, Inc., a subcontractor for Blue Cross Association) and then by a Provider Reimbursement Review Board. The Secretary of Health, Education and Welfare refused to reverse the decisions. In the order of March 1, 1979, this court held that 42 C.F.R. § 405.419(b)(3)(ii) was within the authority of the Secretary under the applicable statute and that denial of reimbursement was supported by substantial evidence in the administrative record that the organizations were related. Still to be decided is plaintiff's claim that the regulation embodies an unconstitutional irrebuttable presumption that the four loans or transactions were illegitimate, unnecessary, or at excessive interest.

The regulation classifies together all loans or interest-bearing transactions between related organizations. The regulation does not provide for individual determination of the necessity of each loan. Denial of interest reimbursement for all such loans is a means toward the general statutory purpose, which is that providers be reimbursed the lesser of the reasonable cost or customary charges for services. 42 U.S.C. § 1395f(b)(1) (Supp. 1979). Reasonable cost is defined as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and [the cost] shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services. . . ." 42 U.S.C. § 1395x(v)(1)(A) (Supp. 1979). The more specific purpose of this regulation is "to assure that loans are legitimate and needed, and that the interest rate is reasonable." 42 C.F.R. § 405.419(c)(1). Plaintiff argues that these purposes are not being served by denial of reimbursement of interest in this case because the four transactions were legitimate and at reasonable interest. Plaintiff insists it is unfair to deny it a chance to show that each transaction was proper despite the relations between the parties. Plaintiff maintains the regulation involves a conclusive presumption of illegitimacy that violates the fifth amendment.

B. The Doctrine of Irrebuttable Presumptions

The doctrine of conclusive or irrebuttable presumptions occupies the borderlands between the doctrines of equal protection and due process. The doctrine contains an element of equal protction in that it involves the claim that a statutory or regulatory classification has been overinclusive; it contains an element of due process in that it involves the claim that a plaintiff has been denied the opportunity to show that the purpose of the statute is not served by including him in the class. Analysis in terms of irrebuttable presumptions in effect imposes a fairly high level of scrutiny of the relationship between the purpose of the statute and the means of the statute or the regulation involved. *See United States Dep't of Agriculture v. Murry,* 413 U.S. 508, 517–20 (1973) (Marshall, J., concurring). The doctrine has been widely criticized as being standardless. It has not been clear what is necessary to trigger invocation of the doctrine. *See* Note, "The Conclusive Presumption Shuffle," 125 *U. of Penn. L. Rev.* 761 (1977); Note, "Irrebuttable Presumptions: An Illusory Analysis," 27 *Stan. L. Rev.* 449 (1975); Note, "The Irrebuttable Presumption Doctrine in the Supreme Court," 87 *Harv. L. Rev.* 1534 (1974); Note, "The Conclusive Presumption Doctrine: Equal Process or Due Protection?," 72 *Mich. L. Rev.* 800 (1974). Courts have concurred in this criticism. *See, e.g., Weinberger v. Salfi,* 422 U.S. 749, 772–73 (1975); *Fairfax Hospital Ass'n, Inc. v. Califano,* 585 F.2d 602, 608 (4th Cir. 1978).

The question is not so much whether irrebuttable presumptions analysis is more closely related to equal protection or due process. The question is how closely should the court scrutinize the relationship between the statutory purpose and the regulatory classification used as a means toward that purpose. By arguing for applicability of the doctrine of irrebuttable presumptions, plaintiff is urging a high level of scrutiny.

C. Review of the Constitutionality of Provisions of Social Welfare Programs

The doctrine of irrebuttable presumptions is not applicable to judicial review of the constitutionality of provisions of social welfare programs. Such provisions receive a fairly low level of scrutiny. The United States Supreme Court has cautiously limited the applicability of irrebuttable presumptions analysis. Though the criteria for applicability have not been extremely clear, it has been obvious that such analysis is not to be applied routinely or indiscriminately to all categories of cases. Further, the Supreme Court has explicitly declined to apply it in analyzing the constitutionality of provisions of a social welfare program. The Court attempted to make this clear in *Weinberger v. Salfi,* 422 U.S. 749 (1975), noting that "our various holdings in related cases do not all sound precisely the same note. . . ." *Id.* at 768. *Salfi* dealt with social security, which, like the Medicare plan at issue in this case, is a social welfare program. Plaintiff Caylor-Nickel Hospital has attempted to support its proposition that a social welfare program should be subjected to irrebuttable presumptions analysis by citing such decisions as *Cleveland Board of Education v. LaFleur,* 414 U.S. 632 (1974); *Vlandis v. Kline,* 412 U.S. 441 (1973); and *Stanley v. Illinois,* 405 U.S. 645 (1972). *LaFleur* concerned rights of marriage and family life, *Stanley* concerned rights to conceive and raise children, and *Vlandis* involved eligibility for resident tuition at a state university. The Supreme Court in *Salfi* explicitly stated: "We hold that these cases are not controlling on the issue before us now. Unlike the claims involved in *Stanley* and *LaFleur,* a noncontractual claim to receive funds from the public treasury enjoys no constitutionally protected status. . . ." 422 U.S. at 771–72. The Court also distinguishsd *Salfi* from *Vlandis. Id.* at 772.[1] The Court approvingly cited such earlier cases dealing with social welfare legislation as *Richardson v. Belcher,* 404 U.S. 78 (1971); *Dandridge v. Williams,* 397 U.S. 471 (1970); and *Flemming v. Nestor,* 363 U.S. 603 (1960). Those cases establish that a statutory classification violates due process only if it is "patently arbitrary . . ., utterly lacking in rational justification." 363 U.S., at 611. They establish that a classification violates equal protection only if it lacks a reasonable basis; there is no violation merely because the classification is "imperfect," or " 'not

[1] To the extent that there is any inconsistency, the standards set forth in the 1975 *Salfi* decision must be followed rather than those set forth in earlier decisions such as *Dep't of Agriculture v. Moreno,* 413 U.S. 528 (1973), and *Dep't of Agriculture v. Murrary,* 413 U.S. 508 (1973). It is not certain that there is any inconsistency, since *Salfi* incorporated those decisions into its explanation of the standards. *See* 422 U.S. at 772. The *Salfi* reluctance to resort to irrebuttable presumptions analysis has been reaffirmed in *Knebel v. Hein,* 429 U.S. 288, 297 (1977). *Knebel* found regulations valid and constitutional even though they did "operate somewhat unfairly in [this] case." 429 U.S. at 294. *Salfi* has been followed in *Fairfax Hospital Ass'n Inc. v. Califano,* 585 F.2d 602 (4th Cir. 1978), upholding what is now 42 C.F.R. § 405.427, another Medicare regulation concerning reimbursement of costs to related organizations. *See also Califano v. Aznavoriah,* 99 S.Ct. 471, 474 (1978); *Califano v. Jobst,* 98 S.Ct. 95, 99 (1977); *Chelsea Community Hospital v. Michigan Blue Cross,* 436 F. Supp. 1050, 1061-62 (E.D. Mich. 1977).

made with mathematical nicety or because in practice it results in some inequality.' " 397 U.S. at 485–86. *Dandridge* further explained:

> To be sure, the cases . . . enunciating this fundamental standard under the Equal Protection Clause, have in the main involved state regulation of business or industry. The administration of public welfare assistance, by contrast, involves the most basic economic needs of impoverished human beings. We recognize the dramatically real factual difference between the cited cases and this one, but we can find no basis for applying a different constitutional standard. . . . *Id.*

Salfi clearly indicated that legislation concerning social welfare was to receive the same low level of scrutiny as legislation regulating business. *Salfi* approvingly cited *Williamson v. Lee Optical Co.*, 348 U.S. 483 (1955), which upheld a scheme of regulation applying to opticians but not to sellers of ready-to-wear glasses. The Court observed in *Salfi* that,

> If the Fifth and Fourteenth Amendments permit this latitude to legislative decisions regulating the private sector, they surely allow no less latitude in prescribing the conditions upon which funds shall be dispensed from the public treasury.

422 U.S. at 773–74.

D. The Constitutionality of 42 C.F.R. § 405.419(b)(3)(ii)

To the extent that Medicare is concerned with "the most basic economic needs of impoverished human beings," it is concerned with the needs of patients, not hospitals. But *Salfi* means that even if a patient were challenging a Medicare provision, the court would apply a low level of scrutiny to the provision. Surely no higher level of scrutiny is warranted when a Medicare provision is challenged by a hospital corporation whose desires for interest reimbursement do not involve the urgency of "the most basic economic needs of impoverished human beings." Related health-care corporations are not a suspect class, and a claim for interest reimbursement is not a fundamental right.

The standards enunciated in *Salfi* apply to review of regulations as well as statutes. *Salfi* cited approvingly *Mourning v. Family Publications Service, Inc.*, 411 U.S. 356 (1973), which held a regulation under the Truth in Lending Act not to be an unconstitutional conclusive presumption. *See* 422 U.S. at 774.

The Medicare regulation which Caylor-Nickel challenges has an effect similar to that of the regulation challenged in *Salfi*. The regulation challenged by Caylor-Nickel forbids reimbursement for interest on loans between related institutions. The statutes challenged in *Salfi* denied social security benefits to a widow and stepchildren if the widow had been married to the deceased wage earner less than nine months prior to his death. The three-judge district court found the purpose of this provision was to prevent the obtaining of benefits by sham marriages and held that the nine-month requirement constituted a conclusive presumption that any given marriage was entered as a sham for this purpose. The district court found the provision unconstitutional, and the Supreme Court reversed, rejecting the district

court's "extension of the holdings of *Stanley, Vlandis,* and *LaFleur*. . . ." 422 U.S. at 767–68, 772.

The Court explained in *Salfi* that the

> question raised is not whether a statutory provision precisely filters out those, and only those, who are in the factual position which generated the congressional concern reflected in the statute. Such a rule would ban all prophylactic provisions, and would be directly contrary to our holding in *Mourning*. . . . Nor is the question whether the provision filters out a substantial part of the class which caused congressional concern, or whether it filters out more members than nonmembers. The question is whether Congress, its concern having been reasonably aroused by the possibility of an abuse which it legitimately desired to avoid, could rationally have concluded both that a particular limitation or qualification would protect against its occurrence, and that the expense and other difficulties of individual determinations justified the inherent imprecision of a prophylactic rule. 422 U.S. at 777.

If it is constitutional to deny social security payments to widows by a provision involving "imprecision," then it must be constitutional to deny interest reimbursement to related health-care corporations by a provision that avoids "individual determinations." *Salfi* dictates that this court reject Caylor-Nickel's characterization of 42 C.F.R. § 405.419(b)(3)(ii) as involving an irrebuttable presumption that all transactions involving organizations related to Caylor-Nickel were illegitimate. The regulation presumes only that many transactions between related institutions are not legitimate, not needed, or not at reasonable interest; the Secretary, acting under statutory authority, has made a policy choice that, in the words of *Salfi,* "limited resources would not be well spent in making individual determinations." 422 U.S. at 784.

This court in its order of March 1, 1979 at 7-9 noted that plaintiff's own accountant had suggested the complicated nature of the operations and interrelationships of what he called the "Caylor-Nickel complex." This court also noted that the fiscal intermediary observed that the interest rates were reasonable. However, this court also expressed its own suspicion that one of the arrangements had no legitimate business purpose other than to create an unnecessary debt, the interest on which would be payable by the federal government. Caylor-Nickel, in its memorandum of April 24, 1979 at 10, argues that refusal to make individual determinations does not conserve administrative resources because there are already

> statutory and administrative procedures in place for a three-tiered administrative determination covering both the necessity and the rate of an interest transaction. Those procedures were utilized in this action and generated an administrative record running more than 400 pages and containing evidence on the nature of each transaction and the money market rates in the community. There is no additional burden to the government in reaching the fair result dictated by the evidence in the administrative record

While it is true that this matter has been before an intermediary, a Provider Reimbursement Review Board, and the Secretary of Health, Education and

Welfare, it is not true that they thoroughly considered and decided the business wisdom and need of each transaction, though they did make some observations on some of the transactions. The administrative proceedings focused not on the nature of the transactions, but on the relations between the organizations, and the decisions were based on those relations under what is now 42 C.F.R. § 405.419(b)(3)(ii). *See* Intermediary Position Statement, undated, at 6–9; Supplement to Intermediary Position Statement, March 11, 1977, at 5–9; Provider Reimbursement Review Board Hearing Decision, June 15, 1977, at 8–9. The Board in the latter hearing explained explicitly that it was not deciding whether these were proper transactions but was only deciding that these were related organizations under the regulation:

> [T]he related party principle was developed to insure against program exploitation through self-dealing or contrived arrangements that would result in more than proper cost reimbursement. Whether or not such a situation existed here is irrelevant because the Regulations are controlling.

Hence, plaintiff is arguing for individual determination of a matter that has not already been decided.[2] The Secretary in 42 C.F.R. § 405.419(b)(3)(ii) seeks to avoid such an additional inquiry and decision, and certainly under the latitude prescribed by *Salfi,* the Secretary is within his authority in deciding that administrative resources should not be expended upon inquiring into the business necessity of every interest-bearing transaction between large, complex, related organizations.

42 C.F.R. § 405.419(b)(3)(ii) was held not to be an unconstitutional irrebuttable presumption in *Hillside Community Hospital v. Matthews,* 423 F. Supp. 1168 (N.D. Cal. 1976). The court noted that *Salfi* was the most recent controlling case. The court found that there was a "reasonable basis" for believing that the denial of interest reimbursement for transactions between related institutions served the purpose of assuring that loans would be legitimate and needed and that interest would be reasonable. 423 F. Supp. at 1176. The court concluded that *Vlandis v. Kline,* 412 U.S. 441 (1975) was distinguishable since the provision in question made residency the basis of lower tuition, but then excluded relevant evidence of residency. 42 C.F.R. § 405.419 makes reimbursement depend on whether or not the organizations are related, but does not exclude relevant evidence of whether the organizations are in fact related.

No court has held 42 C.F.R. § 405.419(b)(3)(ii) unconstitutional. Plaintiff in its April 24, 1979 memorandum, at 9, cites *South Boston General Hospital v. Blue Cross,* 409 F. Supp. 1380 (W.D. Va. 1976), which did not reach the constitutional question, but found that the regulation was contrary to the purposes of the statute, 42 U.S.C. § 1395x(v)(1)(A). Plaintiff argues that if the regulation is contrary to the purpose of the statute, it has

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[2] In its April 24, 1979 memorandum, at 10, plaintiff argues that no additional administrative effort would be required for individual determination of the propriety of each transaction. However, in the same memorandum, at 12-15, arguing in a different context, plaintiff concedes that such determinations in this case would have required extra consideration of factors that were not considered in the administrative hearings.

no reasonable basis and must be found to be an unconstitutional irrebuttable presumption. But in the order of March 1, 1979, this court held that the regulation was valid under the statute.[3] This line of argument need be pursued no further. 42 C.F.R. § 405.419(b)(3)(ii) does not embody an unconstitutional irrebuttable presumption.

II. DIFFERENT TREATMENT OF PROFIT AND NONPROFIT INSTITUTIONS

Plaintiff concludes its April 24, 1979 memorandum, at 16, with a brief protest that 42 C.F.R. §§ 405.419(c)(1) and 405.429(a)(1) taken together mean that in certain situations loans made by related parties may be treated as invested funds, for which a return on equity capital will be allowed to for-profit institutions but not to not-for-profit institutions such as Caylor-Nickel. Plaintiff maintains that this discrimination against not-for-profit providers violates equal protection and due process. These regulations allow a return on investment to profit but not to nonprofit institutions. This is tantamount to saying the regulations provide for profit to profit institutions but not to nonprofit institutions. Surely such a classification has a rational basis that will satisfy *Salfi,* 422 U.S. at 770. It is certainly rational that profit institutions receive this advantage when nonprofit institutions receive numerous other advantages, such as various grants and contributions, and tax-exempt status. The purpose and rationality of this classification is made clear in 42 U.S.C. § 1395x(v)(1)(A) and in the legislative history, which are quoted at length in defendant's memorandum of June 18, 1979, at 7–9, and need not be repeated here. Defendant's arguments at *id.* are entirely persuasive on this point. The distinction drawn between profit and nonprofit institutions violates nothing in the fifth amendment. *See Am. Med. Int'l, Inc. v. Sec. of H.E.W.,* 466 F. Supp. 605, 615 (D.C. Dist. Columb. 1979).

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[3] Though *South Boston* found the regulation invalid under the statute, the opposite conclusion has been reached in both the subsequent *Hillside* decision, 423 F. Supp. at 1177 and in the March 1, 1979 order, at 6-9, of this court. It should be noted that the court that decided *South Boston* not only failed to consider *Salfi,* which had been decided nine months earlier, but also failed to consider any statutory or case law on standards for judicial review of the relation between agency regulations and a statute. This court's March 1, 1979 order, at 7, and *Hillside,* 423 F. Supp. at 1173, did consider such standards as found in *Batterton v. Francis,* 432 U.S. 416 (1977); *Mourning v. Family Publications Service, Inc.,* 411 U.S. 356 (1973); *Thorpe v. Housing Authority of Durham,* 393 U.S. 268 (1969); *Udall v. Tallman,* 380 U.S. 1 (1964); and 5 U.S.C. § 706 (1977).

SECTION 1815, SECTION 1861 (v)(1)(A), SECTION 1878(b) (42 U.S.C. 1395g, 1395x(v)(1)(A), 1395oo(b))—HEALTH INSURANCE—COST REIMBURSEMENT — PROVIDERS AGGREGATING AMOUNTS TO MEET AMOUNT IN CONTROVERSY REQUIREMENT FOR HEARINGS BEFORE PROVIDER REIMBURSEMENT REVIEW BOARD

HCFAR 79–64c

Cleveland Memorial Hospital, Inc., et al., v. Califano, U.S.A., 4th Circuit 594 F.2d 993 (3/30/79).

The Provider Reimbursement Review Board declined to accept jurisdiction in a group appeal since the monetary jurisdictional requirements were not met by the providers using only one cost reporting period collectively. *Held,* that a group of providers appealing the denial of reimbursement under the Medicare program may aggregate more than one cost report from each group member to meet the jurisdictional amount in controversy for group appeals to the Provider Reimbursement Review Board.

HALL, CIRCUIT JUDGE

The single issue presented in this appeal is whether a group of medical care providers, appealing the denial of reimbursement under the Medicare program, may aggregate more than one cost report from each group member to meet the jurisdictional amount for group appeals to the Provider Reimbursement Review Board. The district court held that such aggregation is permitted under Title XVIII of the Social Security Act, 42 U.S.C. § 1395oo(b). We affirm.

STATUTORY BACKGROUND

Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, established the Medicare program which provides, among other things, health insurance for hospital and related post-hospital costs of persons aged 65 or over. Under this program certified "providers of services" [1] do not charge Medicare beneficiaries directly, but rather are reimbursed from the Medicare trust fund for all reasonable costs of providing services to those beneficiaries, either by the Secretary of H.E.W. directly or through a public or private organization called a "fiscal intermediary" which serves as the Secretary's agent.

Each provider is reimbursed at least monthly on an interim basis, subject to later adjustment. At the end of the provider's fiscal year it submits a cost report for that year. The Secretary or fiscal intermediary later determines by audit the actual amount of reimbursement to which the provider is entitled for the year, and gives the provider a "notice of program reimbursement." This determination may be reopened and amended at any time during the 3 years following the notice of reimbursement. If there is a difference

[1] Defined as hospitals, skilled nursing facilities, home health agencies and certain hospital funds. 42 U.S.C. § 1395x(u).

between the reimbursement determined to be due for a cost period (on the basis of either an initial audit or a redetermination) and the payments already made to the provider for that period, an appropriate adjustment is made in subsequent payments to the provider in order to recoup or repay the difference.

A provider dissatisfied with a reimbursement determination by its intermediary may request a hearing by the intermediary if the amount of reimbursement in controversy is at least $1,000 but less than $10,000.[2] The intermediary's hearing decision is not subject to administrative or judicial review.

In 1972, Congress created the Provider Reimbursement Review Board to provide an independent reviewing body for certain intermediary decisions. The conditions for review by the Board, which form the basis for this appeal, are set out in 42 U.S.C. § 1395oo, as follows:

> § 1395oo. Provider Reimbursement Review Board—Establishment.
>
> (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if—
>
> (1) such provider—
>
> (A) is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report,
>
> * * *
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination . . .
>
> (b) The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

FACTUAL BACKGROUND

Plaintiffs are four North Carolina hospitals which provide services under the Medicare program. In late 1975 and 1976 each of the providers was notified by its fiscal intermediary (Blue Cross and Blue Shield of North Carolina) that its claims for nursing education costs were not reimbursable under H.E.W. policy guidelines, and had been disallowed for each cost period in

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[2] The intermediary is not empowered to conduct hearings in cases where its original decision involved a claim of $10,000 or more; rather, the provider must seek review from the Provider Reimbusement Review Board. This $10,000 ceiling on review by the intermediary applies only to cost-reporting periods ending on or after June 30, 1973. 42 C.F.R. §§ 405.1809-.1811 (1977).

which they had been claimed. The disallowed claims at issue[3] are the following:

Provider	1973 Cost Year	1974 Cost Year	1975 Cost Year
Cleveland Memorial Hospital, Inc.	$5,000	$ 6,540	$ 5,200
Grace Hospital, Inc.	0	11,235	8,300
Rutherford Hospital, Inc.	6,200	8,340	8,860
Nash General Hospital, Inc.	14,331	15,484	15,243
Total	$25,531	$41,599	$37,603

The hospitals sought a group hearing under § 1395oo(b) before the Provider Reimbursement Review Board. The Board ruled that under § 1395oo(a) the amount in controversy for an individual appeal is determined by the provider's claim for a single cost year,[4] that this provision was incorporated into § 1395oo(b), and that a group of providers seeking a hearing under § 1395oo(b) must therefore meet the $50,000 jurisdictional amount on the basis of only one cost report per provider. The Board noted however that if a group could meet this jurisdictional threshold, claims from additional cost years would then be considered as part of the appeal.

Since for each individual cost reporting year in issue here, the combined claims of the group failed to meet the $50,000 requirement,[5] the Board dismissed the appeal, but offered to hold four separate hearings on those individual claims which met the $10,000 requirement for single appeals.

The hospitals then brought this action in district court seeking a declaratory judgement that the Board's interpretation of the jurisdictional requirement is not in accordance with applicable law, and an order directing the Board to hear the group appeal. The district court granted the hospital's motion for summary judgment and entered the requested order.

DISCUSSION

We agree with the district court's conclusion that in enacting § 1395oo(b) Congress intended to provide for review by the Board of the type of claims at issue here. The prerequisites for individual appeals under § 1395oo(a),

[3] In the cases of Cleveland Memorial Hospital and Rutherford Hospital, the intermediary reopened its original determinations for cost years extending back to 1968 in order to disallow the nursing education costs. (The intermediary's initial determinations for these earlier years were not made until 1973 or 1974, and the three-year time limit on reopenings begins to run when the initial determination is made.) However, since the jurisdiction of the Provider Reimbursement Review Board is limited to claims arising from cost years ending on or after June 30, 1973, Pub. L. 92-603, § 243 (c), this appeal concerns only claims based on cost reports from 1973 or later.

[4] We express no opinion on the correctness of this interpretation of § 1395oo(a), which has not been questioned in this case.

[5] The Board left open the question of whether the providers could meet the jurisdictional amount by aggregating each hospital's largest single claim, since even this procedure would not enable the group to meet the $50.000 requirement.

with the exception of the amount in controversy requirement, also apply to group appeals under § 1395oo(b), so that each claim included in the group appeal must stem from an adverse final determination[6] by the intermediary based on a cost report which was filed by the provider within the applicable time requirements. 42 U.S.C. § 1395oo(a)(1). In addition, a claim may be included in the group appeal only if the provider filed a request for a hearing within 180 days after notice of the intermediary's final determination on the claim.[7] 42 U.S.C. § 1395oo(a)(3).

The parties agree that the claims at issue here satisfy all these requirements and that they all involve a common question of law or fact. The only remaining prerequisite for a group appeal is that "the amount in controversy is, *in the aggregate,* $50,000 or more." 42 U.S.C. § 1395oo(b) (emphasis supplied).

The claims involved in this appeal, all of which will be considered together by the Board in a group appeal if jurisdiction is established, total $104,733. We believe that this figure, the aggregate amount of the claims properly considered in a group appeal, is also the "amount in controversy" for purposes of determining whether the jurisdictional requirement is met. The Board's distinction, by which one figure determines the scope of the appeal and another determines jurisdiction, is without foundation in either the statute or the applicable regulation.[8] It is also unrelated to the purpose of the amount in controversy requirement, which is to ensure the substantiality of issues raised before the Board.

The legislative history of § 1395oo, although relatively brief, shows a clear intent to provide an independent review of reimbursement decisions by fiscal intermediaries which involve significant issues. The original House version of the legislation (subsection (a) of the current statute) provided only for individual appeals and ensured the significance of the issue concerned by setting a $10,000 jurisdictional requirement. H. REP. NO. 92-231, *reprinted in* 1976 U.S. CODE CONG. & ADM. NEWS 4989, 5308-5310. The Senate, apparently recognizing that the overall impact of an intermediary's deter-

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[6] The provider also has a right to a hearing if it has not received a determination by the intermediary within 12 months after it filed a proper cost report. 42 U.S.C. § 1395oo(a)(1)(B),(C); 42 C.F.R. § 405.1835 (1977).

[7] This 180-day filing requirement will, in most cases, limit group appeals to claims based upon the single most recent cost report of each group member. A group member usually will have received final determinations on claims covering a number of years within a time period short enough to meet the 180-day requirement only where the intermediary has not rendered a prompt determination on a cost report, or where the intermediary has reopened prior determinations to disallow a series of similar claims. In the latter situation, exemplified by this case, the intermediary's action will typically be based upon policy considerations and so will present particularly appropriate issues for resolution by the Board and for review by the courts.

[8] H.E.W. regulations provide the following method of determining whether the claims of a group of providers meet the $50.000 jurisdictional amount:

> The $50,000 amount in controversy will be computed by deducting the adjusted total reimbursable program costs (in the aggregate) from the total reimbursable program costs (less any amounts excluded by section 1862 of the Act) which are claimed in the aggregate by the providers and are related to a common issue or interpretation of law or regulations. 42 C.F.R. § 405.1839(b) (1977).

mination could be significant even where the amount denied to any single provider was relatively small, added a provision for group appeals where the claims of the entire group aggregate $10,000. H. CONF. REP. NO 92-1605, *reprinted in* 1972 U.S. CODE CONG. & ADM. NEWS 5370, 5387-5388. The conference committee adopted this provision for group appeals after raising the required aggregate amount in controversy to $50,000. *Id.* The statute was amended in 1974 to provide for judicial review of all final decisions by the Provider Reimbursement Review Board, and the conference report on the amendment succinctly describes the purpose of § 1395oo: the creation of an independent body "to review and decide upon *substantial* reimbursement issues raised by providers of services." H. CONF. REP. NO. 93-1407, *reprinted in* 1974 U.S. CODE CONG. & ADM. NEWS 5995-5996 (emphasis supplied).

It is unquestioned that the issue raised by the claims in this case is a substantial one. Four of the eleven individual claims involve amounts sufficient to entitle the providers to individual appeals. Absent a clear indication that Congress intended such a result, we cannot accept an interpretation of the statute's jurisdictional amount provision which would require the Board to hold four separate hearings on claims involving an identical issue, but would preclude it from holding a single hearing combining those four claims with seven others involving the same issue.

We find no such intent in the statute or its history. The statute says that group members may aggregate their claims to reach the $50,000 amount in controversy requirement. The plain meaning of this provision is that *all* claims which are properly joined in a group appeal—those which involve common questions of law or fact and for which timely initial claims and notices of appeal were filed—may be aggregated to meet the jurisdictional amount in controversy. Therefore, the judgement of the district court is

AFFIRMED.

SECTION 1842(b)(5) (42 U.S.C. 1395u(b)(5))—SUPPLEMENTARY MEDICAL INSURANCE—ASSIGNMENT OF MEDICARE PAYMENTS TO A PHYSICIAN CORPORATION

Northeast Emergency Medical Associates, et al., v. Califano, 470 F. Supp. 1111 (E.D. Pa 1979), aff'd, No. 79 1829 (3rd Cir. January 14, 1980)

HCFAR 79–65c

Professional corporations, which staff hospital emergency rooms with physicians who work for the corporations as independent contractors rather than as employees, had been receiving assigned Medicare Part B payments for the physician services. Under the Secretary's interpretation of section 1842(b) of the Social Security Act, a patient may assign Medicare Part B payments for physician services only to the physician himself or, under certain circumstances, to his employer or to the facility in which he furnished the service.

Upon instructions from HCFA, the Medicare carrier stopped issuing Part B payments to the corporations. The corporations allege that (1) the Secretary's interpretation of section 1842(b)(5) is erroneous, and (2) the Secretary deprived them of property without due process of law because HCFA provided no prior hearing on the interpretation of section 1842(b)(5).

The Court finds that under section 205(h) of the Social Security Act it lacks jurisdiction to review the Secretary's interpretation of section 1842(b)(5).

The Court accepts jurisdiction of the constitutional question of whether the Secretary deprived the corporations of a protected property without due process of law.

Held, the Secretary did not deprive the corporations of property without due process of law because (1) the corporations do not have a property interest in receiving assigned Part B benefits—the beneficiaries are the only real parties in interest; and (2) even if the corporations have a property interest, HCFA met the minimum requirements of due process by providing timely notice, a statement of reasons, and an opportunity for the corporations to present their views in writing before HCFA terminated assignments of Part B payments to them.

LUONGO, DISTRICT JUDGE:

This civil action stems from a dispute over the proper interpretation of section 1842(b)(5) of the Social Security Act, 42 U.S.C. §1395u(b)(5) (1976), *as amended by* Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, §2(a)(1), 91 Stat. 1175 (1977). The corporate plaintiffs, under contracts with several Pennsylvania hospitals, have furnished physicians' services and other services in the emergency rooms of those hospitals since 1976. A Medicare patient treated in one of these emergency rooms typically assigns his right to receive Part B Medicare benefits for the emergency-room services to the particular corporate plaintiff involved, as payment for those services, and the benefits are then paid directly to that corporation by Pennsylvania Blue Shield, a local Medicare insurance carrier. *See generally* 42 U.S.C.A. §1395u (West 1974 & Supp. 1978). Late in 1978, however, Pennsylvania Blue Shield determined, after some prodding by the

Medicare Bureau,[1] that section 1842(b)(5) of the Social Security Act prohibits assignments of this type, and that payments would thereafter be made to the individual attending physician(s), rather than to plaintiff corporations. Plaintiffs filed this action, seeking a declaration that defendants—the Director of Technical Policy within the Medicare Bureau, the Secretary of HEW, and the Department of HEW—have misinterpreted the law, and that section 1842(b)(5) does *not* bar the assignment of benefits to the corporate plaintiffs. In addition, plaintiffs urge that they were denied procedural due process when defendants informally adopted their unfavorable interpretation of that provision without affording plaintiffs a prior hearing. Defendants now seek either (1) dismissal of the complaint for lack of subject-matter jurisdiction, or (2) summary judgment in their favor, and plaintiffs in turn seek summary judgment in *their* favor. For the reasons hereafter stated, I conclude that subject-matter jurisdiction is lacking with respect to plaintiffs' statutory claim, and that defendants are entitled to summary judgment on the merits of plaintiffs' constitutional claim.

The facts here are undisputed. In 1978, the regional office of the Medicare Bureau undertook a review of "reassignment accounts" established by Medicare insurance carriers in Region III. This review disclosed that Pennsylvania Blue Shield had established—and paid reassigned benefits into—six such accounts. Although each account bore a different corporate or fictitious name, each represented emergency-room services rendered by physicians under contract to Northeast Emergency Medical Associates, P.C. (NEMA), the first-named corporate plaintiff in this action. The Medicare Bureau then sought further information about NEMA from Pennsylvania Blue Shield, so that it could determine whether section 1842(b)(5) prohibited the reassignment of benefits under these circumstances.

In August of 1978, the director of the Bureau's Division of Program Operations wrote to a Mr. Tolin of Pennsylvania Blue Shield. Attachment A to Defendant's Motion (Document No. 6). His letter stated in part:

> "Based on the information submitted, we do not believe that there was sufficient evidence to justify approval of [some of the NEMA] accounts. We realize that you are currently implementing new procedures for approving reassignment accounts and are currently updating all previously approved accounts. Nevertheless, we request that you immediately contact [NEMA] and review the validity of [the] accounts. We would also like you to verify whether or not the payments made by [NEMA] to the physicians are reported to the Internal Revenue Service on Form W-2.
>
> In the event you find that [NEMA] is receiving payments for services rendered by physicians not in its employ, you should stop making payments to [NEMA] for services rendered by non-employee physicians. [NEMA] may continue to receive payments for those physicians documented to be in its employ. Finally, we would like you to complete action on this matter as soon as possible and report your findings to us."

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[1] The Medicare Bureau is part of the Health Care Financing Administration, which in turn is part of the Department of Health, Education and Welfare.

Pennsylvania Blue Shield apparently cooperated fully with this request of the Medicare Bureau. According to the affidavit submitted by the Bureau's regional director:

> "After examination of the contracts between the hospital[s] and NEMA, extensive correspondence with NEMA, and meetings between the carrier's employees and NEMA officers and its attorney, it was established that no employer-employee relationship existed between NEMA and the physicians who provided the medical services for which assignment had been made. The conclusion was based on the admission by NEMA that the physicians it supplies to hospitals are 'independent contractors' under subcontract, and on various indicia that support that admission, e.g., physician payments reported to the Internal Revenue Service on Form 1099 rather than on Form W-2."
>
> Hartman Aff. ¶3.

On November 20, 1978, Pennsylvania Blue Shield sent a series of letters to plaintiff Caskey. Each letter dealt with one of the NEMA reassignment accounts, and each stated that the account "will be dissolved effective immediately and will be removed from our files as an eligible provider thirty (30) days from the date of this letter (Decembr 19, 1978)." Exhibits A-E to Complaint (Document No. 1). Each letter also stated that all future claims for Medicare benefits would "be processed and paid under the name and number of the individual doctor performing the services." *Id.* By way of explanation, Pennsylvania Blue Shield stated that, under the Social Security Act, benefits could be reassigned to a group or corporate entity *only* where that entity either employed the physicians who actually performed the services or satisfied one of two other exceptions that are not material here. As the earlier correspondence quoted above confirms, Pennsylvania Blue Shield and the Medicare Bureau found that the absence of an employer-employee relationship between NEMA and the emergency-room physicians invalidated the several reassignment accounts that involve NEMA.

On January 2, 1979, plaintiffs' counsel wrote to defendant Katz, the Director of Technical Policy for the Medicare Bureau. Exhibit F to Complaint (Document No. 1). In that letter, counsel emphasized that the restrictions of section 1842(b)(5) applied only where payments were assigned to someone *other than* the patient who received the service or "the physician or other person who provided the service." Counsel argued that NEMA was a "person" who "provided" emergency-room services within the meaning of that provision so that benefits could be reassigned to NEMA without regard to whether an employer-employee relationship existed between NEMA and the physicians who actually performed the emergency-room services. Finally, counsel asked that "the Department" reconsider its determination with respect to NEMA, and added: "In the event the Department's decision is not changed, [NEMA] wishes to exercise its right under the Social Security Act to a hearing by the Secretary [of HEW] and specifically requests that such a hearing be scheduled in this matter as soon as possible."

On February 2, 1979, defendant Katz replied to counsel's letter as follows:

"This is in reply to your letter of January 2, 1979, asking that we rescind the decison made by the Medicare carrier, Pennsylvania Blue Shield, to deny Medicare Part B benefits to [NEMA]. [NEMA] has been receiving such payments for the physician services that it makes available to hospital emergency rooms through subcontracts with independent physicians.

The basis for the carrier's decision denying payment to [NEMA] is section 1842(b)(5) of the Social Security Act, which provides that assigned Medicare Part B benefits may not be paid to anyone other than the physician or other person who [provided] the service, subject to certain exceptions which permit payment to the physician's or other person's employer or [to] the facility in which the physician or other person furnished the services.

You argue that [NEMA], as a professional corporation, is a person within the meaning of [section 1842(b)(5)] and that it *provides* physician services in hospital emergency rooms through independent subcontractor physicians.

We agree that [NEMA] is a person but do not agree that it *provides* physician services (and especially not the services of independent subcontractor physicians). Under the legislative scheme reflected in the Medicare law, only physicians provide physician services. That is why special provision was necessary for payment to employers [of physicians] and [to] medical facilities for physician services. (Corporations provide only non-physician services.)

When the prohibition against reassignment . . . was enacted in 1972, the use of the professional corporation organizational structure had only recently become widespread. There is no evidence that Congress considered the professional corporation to be a provider of physician services.

. . . Since [NEMA] cannot be viewed as providing physican services and is not the employer of the physicians or the facility in which the physicians provide the services, the carrier's decision to deny payment on the claim is correct under the law.

Neither section 1869 of the Social Security Act nor any other section of that law provides a right of appeal to the Secretary on a Part B claim. Upon denial of his Part B claim, a claimant may request an independent review of that decision by the carrier. If the claimant is dissatisfied with the review decision, and the controversy involves $100 or more, the claimant may request a hearing before a hearing officer of the carrier. . . . Program regulations . . . require that the hearing officer, in exercising the authority to conduct a hearing, and render a hearing decision is to comply with all the provisions of title XVIII of the Social Security Act and regulations issued thereunder, as well as with policy statements, instructions and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carriers. Thus, in deciding whether [NEMA] is a party entitled under the law to receive assigned Part B payments, the hearing officer would be guided to a large extent by the criteria in sections 3060-3060.3 of the Medicare Carrier's Manual."

Exhibit G to Complaint (Document No. 1) (emphasis in original).

On February 14, 1979, the Director of Professional Relations at Pennsylvania Blue Shield wrote to plaintiff Caskey. In part, this letter stated:

"The Medicare Bureau has provided me with a copy of Mr. Katz's letter of February 2, 1979 to [plaintiffs' counsel]. Based on the contents of that letter . . . I will remove the . . . six [NEMA] accounts from the Pennsylvania Blue Shield file on February 22, 1979. . . .

> Effective February 22, all Medicare Part B . . . claims submitted must be generated in the individual name of the doctor performing the service. Any claims submitted in the name of [NEMA] will be delayed until we can identify the specific doctor who provided the service."
>
> Attachment B to Defendants' Motion (Document No. 6).

As the same letter made clear, Pennsylvania Blue Shield would also cease paying into the NEMA accounts for services rendered to Blue Shield subscribers who were *not* covered under Medicare. Blue Shield "stated to plaintiffs that in order to maintain uniformity in and processing of medical claims by their office and considering the fact that they are the intermediary for 'Medicare,' they also will no longer pay plaintiffs for medical services rendered to their subscribers." Affidavit in Support ¶17, Exhibit BB to Plaintiffs' Motion (Document No. 5).

Plaintiffs filed the complaint in this action on February 13, 1979. They initially sought a temporary restraining order and a preliminary injunction, but counsel then advised the court of an agreement whereby termination of the NEMA reassignment accounts was postponed until March 26, 1979. As a result, plaintiffs no longer sought interim relief, but chose instead to await a ruling on the merits of their claims in the normal course of judicial business.

In their complaint and in their brief, plaintiffs rely on two provisions of the Judicial Code as alternative bases for jurisdiction here: general federal-question jurisdiction, 28 U.S.C. §1331(a) (1976), *as amended* by Pub. L. No. 94–574, §2, 90 Stat. 2721 (1976), and the mandamus statute, 28 U.S.C. §1361 (1976). Defendants contend that neither provision can properly support jurisdiction. As is so often the case with litigation under the Social Security Act, the question whether subject-matter jurisdiction exists here is at least as difficult as any question bearing on the merits of this action. The parties to this litigation at first focused largely on the merits, and at oral argument I asked counsel to file supplemental briefs on the jurisdictional problems presented here. I have reviewed those supplemental briefs, and I shall now proceed to consider whether either of the provisions cited above can support jurisdiction over part or all of plaintiffs' case.

The Medicare program is governed by subchapter XVIII of the Social Security Act, 42 U.S.C.A. §§1395–1395qq (West 1974 & Supp. 1978). Section 1872 of the Act, 42 U.S.C. §1395ii (1976), states that several provisions of subchapter II, most notably 42 U.S.C. §405(h) (1976), "shall also apply with respect to [subchapter XVIII] to the same extent as they are applicable with respect to subchapter II of [the Social Security Act]." Section 405(h) contains both a general limitation on judicial review[2] and a specific limitation on federal-court jurisdiction.[3] By virtue of the provision

[2] The second sentence of section 405(h) reads as follows: "No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided."

[3] The third sentence of section 405(h) reads as follows: "No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter."

just quoted, these limitations apply with respect to subchapter XVIII—the subject of this action—to the same extent that they apply with respect to subchapter II. Thus, the interpretation of section 405(h) is central to the determination whether plaintiffs may base jurisdiction here on either 28 U.S.C. §1331(a) or 28 U.S.C. §1361.

STATUTORY CLAIM

Plaintiffs' principal claim is that defendants have misinterpreted section 1842(b)(5) of the Social Security Act. That provision, by its very terms, permits the assignment of Part B Medicare benefits to "the physician or other person who provided the service,"' and plaintiffs argue forcefully that NEMA is a person providing services within the meaning of section 1842(b)(5). But I may not resolve this question on the merits, for I believe that section 405(h) prevents me from exercising jurisdiction over this aspect of plaintiffs' case.

The second sentence of section 405(h) states that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided." Although Pennsylvania Blue Shield, rather than the Secretary, actually terminated the NEMA reassignment accounts, the facts recited above make it plain that the carrier took this action only because the Medicare Bureau had interpreted section 1842(b)(5) to preclude the reassignment of benefits to NEMA. Under the circumstances, I believe that plaintiffs seek review of "a decision of the Secretary"—albeit an informal one—and that the second sentence of section 405(h), quoted above, must therefore be reckoned with.[4] *See generally* 42 U.S.C. §405(l) (1976) (authorizing the Secretary to delegate his powers and duties); *id.* §1395ii (incorporating §405(l) into subchapter XVIII).

The second sentence of section 405(h) precludes judicial review of the Secretary's decisions "except as herein provided." Section 405(h) appears in subchapter II, and the words "as herein provided" refer directly to section 405(g), which provides for judicial review of certain decisions made by the Secretary. In the context of subchapter XVIII, however, those words must be read as a reference to the provisions *in subchapter XVIII* that authorize judicial review. Although subchapter XVIII contains several provisions that authorize judicial review of certain findings or decisions made by the Secretary, 42 U.S.C. §§1395ff, 1395*oo*(f) (1976), nothing in subchapter XVIII purports to authorize judicial review of a decision by the Secretary that a Part B claimant (such as NEMA) is not a person providing services within the meaning of section 1842(b)(5). In short, this is not a case where the plaintiff seeks to bypass the review mechanisms prescribed by Congress in the Social Security Act. Instead, plaintiffs invoke 28 U.S.C. §1331 and 28 U.S.C.

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[4] My conclusion that the second sentence of section 405(h) precludes the assumption of jurisdiction over plaintiffs' statutory claim makes it unnecessary for me to consider plaintiffs' contention that jurisdiction over that claim is *not* barred by the third sentence of section 405(h).

§1361 only because the Social Security Act itself makes no provision at all for judicial review of the decision that has harmed them.[5]

Unfortunately, plaintiffs never squarely confront the broad, preclusive language of section 405(h). Their main jurisdictional argument is that the second sentence of section 405(h), quoted *supra,* is somehow inapplicable where jurisdiction is based on the mandamus statute, 28 U.S.C. §1361 (1976). For the reasons set out below, I cannot accept this argument. Although some courts have entertained *constitutional* or *procedural* questions under section 1361 in the face of section 405(h),[6] and although the cases dealing with section 1361 in the context of the Social Security Act are certainly confused,[7] section 405(h) does not simply dissolve whenever an aggrieved claimant invokes the mandamus statute.

I see nothing in this case that warrants an "exception" to the rule of section 405(h). Plaintiffs raise, in the main, an issue of statutory interpretation, and they seek a declaration that defendants have misinterpreted the statute. Such a declaration, of course, would remove the only obstacle that now prevents plaintiffs from receiving reassigned benefits. In short, this action resembles many actions challenging *regulations* adopted by the Secretary that restricted, in various ways, the amount of reimbursement that health-service providers could receive. Jurisdiction over such challenges to regulations has generally been found to be precluded by section 405(h).[8] Although those cases turn on the *third* sentence of section 405(h), quoted *supra* note 3, and are therefore not directly controlling here, they demonstrate that section 405(h) effectively precludes jurisdiction over many actions seeking review of the Secretary's interpretation of the Social Security Act. Thus, the absence

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[5] Plaintiffs could have obtained a hearing on Pennsylvania Blue Shield's decision to terminate the NEMA reassignment accounts. *See* 42 U.S.C. §1395u(b)(3)(C) (1976); 42 C.F.R. §§405.801-.872 (1977). This hearing would have been held before a hearing officer designated by Pennsylvania Blue Shield, 42 C.F.R. §405.823 (1977), and his decision would have been final, *id.* §405.835, unless reopened by him or by Pennsylvania Blue Shield in accordance with §405.841. *See generally Davis v. United States Dep't of HEW,* 416 F. Supp. 448 (S.D.N.Y. 1976) (rejecting due process challenge to the hearing procedures). Plaintiffs apparently have not sought such a hearing, for rather obvious reasons. They seek review of a decision, implemented by the carrier, that was based entirely on defendants' interpretation of the law. Defendants, and not the carrier, are charged with interpreting the statute, and a hearing officer designated by the carrier would have no authority to supersede defendants' decision that §1842(b)(5) bars the reassignment of benefits to NEMA. *See* 42 C.F.R. §405.1829(a) (1976). Indeed, defendant Katz suggested as much in the last paragraph of his February 2, 1979 letter to plaintiffs' counsel, quoted *supra.*

[6] *See, e.g., Elliott v. Weinberger,* 564 F.2d 1219, 1225-28 & n.9 (9th Cir. 1977), *cert. granted sub nom. Califano v. Elliott,* 47 U.S.L.W. 3221 (U.S. Oct. 2, 1978) (No. 77–1511); *White v. Mathews,* 559 F.2d 852, 855-56 (2d Cir. 1977); discussion *infra.*

[7] *Compare John Muir Mem. Hosp., Inc. v. Califano,* 457 F. Supp. 848, 857 (N.D. Cal. 1978) ("In most instances . . . the courts have included [§1361] within the statutory bars of §405(h).") *with Caswell v. Califano* 435 F. Supp. 127, 132-33 (D. Me. 1977) ("lower federal courts confronted with analagous cases arising under the Social Security Act have consistently found mandamus jurisdiction to be present"), *aff'd. on other grounds,* 583 F. 2d 9 (1st Cir. 1978).

[8] *See, e.g., Humana of South Carolina, Inc. v. Califano,* 590 F.2d 1080 (D.C. Cir. 1978); *American Ass'n of Councils of Medical Staffs v. Califano,* 575 F.2d 1367 (5th Cir. 1978), *cert. denied,* 47 U.S.L.W. 3482 (U.S. Jan. 15, 1979).

from subchapter XVIII of any authorization for the instant lawsuit is scarcely a good reason to base jurisdiction on the mandamus statute, in the face of section 405(h). On the contrary, the second sentence of that section means, in this context, that defendants' decision is reviewable as provided in subchapter XVIII "or not at all." *Califano v. Sanders,* 430 U.S. 99, 110 (1977) (Stewart, J., concurring in the judgment).

Nor can I accept the suggestion—implicit in plaintiffs' brief—that mandamus actions in general are so different from other types of challenges to the Secretary's interpretations that they should be exempted from the operation of section 405(h). True, plaintiffs here allege that the defendants' reading of section 1842(b)(5) is clearly inconsistent with the plain meaning of that provision. *All* mandamus plaintiffs are expected to plead legal conclusions like this if they seek to base jurisdiction on section 1361. *See, e.g., Cervase v. Office of Fed. Register,* 580 F.2d 1166, 1174-76 & n.12 (3d Cir. 1978) (Garth, J., dissenting); *Mattern v. Weinberger,* 519 F.2d 150, 155-57 & n.13 (3d Cir. 1975), *vacated on other grounds and remanded sub nom. Mathews v. Mattern,* 425 U.S. 987 (1976). But I see no reason why the preclusive effect of section 405(h) should turn on whether the Secretary's error is alleged to be clear, on the one hand, or subtle, on the other. To permit review under section 1361 of alleged "clear" errors in statutory interpretation would be to rewrite the second sentence of section 405(h) so as to exclude mandamus actions. Such an approach runs counter to the plain language of that sentence, quoted *supra* note 2. *See Califano v. Sanders,* 430 U.S. 99, 109-11 (1977) (Stewart, J., concurring in the judgment). And even if such an approach were supported by substantial policy considerations, federal judges nevertheless ought not to "imply jurisdiction because we think it ought to exist where Congress has literally given none." *Dr. John T. MacDonald Foundation, Inc. v. Mathews,* 554 F.2d 714, 719 (5th Cir. 1977) (Clark, J., dissenting), *vacated sub nom, Dr. John T. MacDonald Foundation, Inc. v. Califano,* 571 F.2d 328 (5th Cir. 1978) (en banc), *cert. denied,* 47 U.S.L.W. 3246 (U.S. Oct. 10, 1978). Accordingly, I conclude that defendants' motion to dismiss the complaint for lack of subject-matter jurisdiction should be granted with respect to plaintiff's statutory claim.

CONSTITUTIONAL CLAIM

Plaintiffs also assert a constitutional deficiency in defendants' actions vis-a-vis the NEMA reassignment accounts. This contention is set forth in their brief as follows:

> "Through their relationship with Medicare since 1976, plaintiffs' rights to continue this relationship have risen to a statutory entitlement as set forth in *Boldberg v. Kelly,* 397 U.S. 254 (1969). . . . Plaintiffs, therefore, are entitled to procedural due process prior to their termination. The procedural due process mandated under *Goldberg v. Kelly,* supra, has been denied to plaintiffs.
>
> Plaintiffs have not received, but seek, a pre-termination evidentiary hearing, timely and adequate notice of such hearing, and an effective opportunity to defend by confronting adverse witnesses and by presenting their argu-

ments and evidence orally before an impartial decision maker. *Goldberg v. Kelly,* supra."

Plaintiffs' Memorandum of Law (Document No. 5) at 19.

The threshold question, once again, is whether I may assume jurisdiction over this claim based on either 28 U.S.C. §1331 or 28 U.S.C. §1361. So far as logic and statutory construction are concerned, the foregoing discussion with respect to plaintiffs' *statutory* claim would dictate that jurisdiction is again lacking. But a different result is required here, for two separate reasons. First, the availability of judicial review is presumed where a constitutional question is asserted. Second, plaintiffs challenge the procedure(s) employed by the Secretary, rather than the merits of his decision. Both of these considerations suggest that section 405(h) does not preclude jurisdiction over this portion of plaintiffs' case.

As the First Circuit recently observed, "courts have hesitated to read [*Weinberger v. Salfi,* 422 U.S. 749 (1975)] and §405(h) to foreclose all avenues of judicial review when the [Social Security] Act provides for *no* administrative process leading to judicial review and constitutional questions are at issue." *Rhode Island Hosp. v. Califano,* 585 F.2d 1153, 1157 (1st Cir. 1978) (emphasis in original) (citations omitted). This hesitation stems from the notion that it would be "extraordinary," *Wienberger v. Salfi,* 422 U.S. 749, 762 (1975), for Congress to effectively insulate a statutory program from constitutional challenge by curtailing federal-court jurisdiction, so that " 'clear and convincing' evidence would be required," *id.* (quoting *Johnson v. Robison,* 415 U.S. 361, 373 (1974)), for a court to find that Congress intended such a result. And once a court concluded that Congress *did* seek to foreclose all judicial review, "a serious constitutional question of the validity of the statute as so construed" would then arise. 422 U.S. at 762. *See generally* Hart, *The Power of Congress to Limit the Jurisdiction of Federal Courts:An Exercise in Dialectic,* 66 Harv. L. Rev. 1362 (1953). These considerations led the Ninth Circuit to emphasize "[t]he distinction between due process questions divorced from a claim for benefits and [non-constitutional] questions related to the merits of a benefits claim." *Elliott v. Weinberger,* 564 F.2d 1219, 1226 & n.9 (9th Cir. 1977), *cert, granted sub nom. Califano v. Elliott,* 47 U.S.L.W. 3221 (U.S. Oct. 2, 1978) (No. 77–1511).

Another line of cases has carved out an even broader "exception" to the preclusive language of section 405(h). These cases focus on whether the alleged deficiency in the Secretary's actions is substantive or procedural. Where a claimant attacks the *merits* of the Secretary's decision, section 405(h) applies in full force. But "when suit is brought simply to vindicate an interest in procedural regularity," that provision "is not summoned into play." *Humana of South Carolina, Inc. v. Califano,* 590 F.2d 1070, 1080 (D.C. Cir. 1978) (footnote omitted); *see* cases collected *id.* n.76. The claimant may argue, as plaintiffs do here, that the due process clause mandated certain procedures before the Secretary took the challenged action. But so long as the alleged deficiency is procedural, rather than substantive, the claimant need not rely on the Constitution. *See, e.g., White v. Mathews,* 559 F.2d 852, 856 (2d Cir. 1977). Thus, one district judge exercised jurisdiction

under section 1361 in a case where applicants for disability insurance benefits claimed that both the due process clause and the Social Security Act entitled them to reasonably prompt hearings on their applications. *See Caswell v. Califano,* 435 F. Supp. 127, 132-33 (D. Me. 1977) (alternative holding), *aff'd on other grounds,* 583 F.2d 9 (1st Cir. 1978). And the Court of Appeals for the D.C. Circuit recently found section 405(h) inapplicable to a procedural challenge grounded solely in the Administrative Procedure Act. *See Humana of South Carolina, Inc. v. Califano,* 590 F.2d 1070 (D.C. Cir. 1978). The claimant there argued that the Secretary, in adopting a regulation limiting reimbursement of certain Medicare providers, "failed to adhere to the methodology generally applicable to any rulemaking effort." *Id* at 1080. That contention, in the court's view, fell "outside the purview" of section 405(h). *Id.*

The challenge that plaintiffs raise here—the argument that they should have been afforded a prior evidentiary hearing before the Secretary (or his delegates) took action that affected them—comes within both of these "exceptions" to section 405(h). Plaintiffs advance a constitutional deficiency in the Secretary's actions, and they challenge those actions on procedural grounds that are entirely distinct from the merits of the underlying issue of statutory interpretation. Under the circumstances, I conclude that section 405(h) does not bar the assumption of jurisdiction over this portion of plaintiffs' case. Specifically, I find at this time that 28 U.S.C. §1331 provides a basis for jurisdiction. Accordingly, defendants' motion to dismiss the complaint will be denied with respect to this aspect of the case, and I shall turn now to the merits of plaintiffs' contention.

Plaintiffs urge that they were deprived of "property" without procedural due process when defendants determined, without affording plaintiffs a prior evidentiary hearing, that section 1842(b)(5) of the Social Security Act bars the reassignment of benefits to the corporate plaintiffs. A review of the complaint and the motion papers filed by plaintiffs reveals that they seek declaratory (and perhaps injunctive) relief from this allegedly unconstitutional action taken by defendants. As the following brief discussion should demonstrate, however, defendants are entitled to summary judgment on two alternative grounds: (1) their actions did not deprive the corporate plaintiffs of any "property" interest encompassed by the fifth amendment's due process clause, and (2) even assuming the existence of a "property" interest, plaintiffs were afforded the minimal procedures required by the due process clause in this context.

To begin with, the corporate plaintiffs' ability to receive reassigned Medicare Part B benefits does not amount to a "property" interest. The First Circuit recently reached this very issue in a slightly different factual context, and part of its discussion bears quotation here:

> "The Medicare Part B program is nothing more than a governmental insurance program for the aged. As such the real parties in interest are the beneficiaries; physicians are parties in interest only as assignees of the beneficiaries. Unlike the welfare benefits of *Goldberg v. Kelly,* which were 'a matter of statutory entitlement for persons qualified to receive them,' 397 U.S. at 262, 90 S. Ct. at 1017, physicians do not have a protectable property interest in their continuing eligibility to bill for reimbursement

under Part B. If services rendered by a physician are disentitled from Part B eligibility, the physician can either not perform the services or bill the patient directly."

Cervoni v. Secretary of HEW, 581 F.2d 1010, 1018 (1st Cir. 1978).

In addition to the two alternatives just mentioned—ceasing to provide services or billing patients directly—the corporate plaintiffs here apparently have a third option. They can arrange to have their Medicare patients assign benefits to the individual physicians who actually perform the services, and they can then recover from those physicians any amount in excess of the compensation specified in their agreements with the physicians. Thus, the termination of the NEMA reassignment accounts did not deprive the corporate plaintiffs of any "property" interest.

Defendants' actions have obviously disrupted plaintiffs' financial arrangements with both (1) the hospitals whose emergency rooms they staff and (2) the physicians who actually perform the emergency-room services. As I have already noted, however, plaintiffs had no "property" interest in their ability to receive reassigned benefits. Thus, although plaintiffs may have undertaken various contractual obligations on the assumption that they would remain eligible for reassignments, the disruption of those contractual arrangements did not deprive plaintiffs of "property" encompassed by the due process clause of the fifth amendment.

Alternatively, even if plaintiffs were deprived of "property" by defendants' actions, it by no means follows that they should have been afforded a prior evidentiary hearing. Due process mandates a trial-type evidentiary hearing *only* where so-called "adjudicative facts" are in dispute. *See generally* Advisory Committee Note to Fed. R. Evid. 201(a), 56 F.R.D. 183, 201-04 (1972) (reviewing the distinction between adjudicative facts and legislative facts). On the record here, however, it is clear that no adjudicative facts were in dispute. Defendants initially directed Pennsylvania Blue Shield to terminate the NEMA accounts when they determined that the emergency-room physicians were independent contractors, rather than NEMA employees. That determination was based in large part on information supplied by NEMA, and plaintiffs have never suggested that the physicians were actually employees of NEMA. When plaintiffs' counsel wrote to defendant Katz, suggesting that the corporate plaintiffs could receive reassigned benefits *even though* they did not employ the emergency-room physicians, Katz advised him (in the letter quoted earlier) that NEMA was not a person providing services within the meaning of section 1842(b)(5) of the Act. That determination was precisely the statutory interpretation that plaintiffs challenge here. As Katz's letter reveals, it was based on his understanding of the congressional intent. Katz also had the benefit of the three-page letter written by plaintiffs' counsel, which described the arrangements among the corporate plaintiffs, the emergency-room physicians, and the hospitals. Exhibit F to Complaint (Document No. 1). Plaintiffs have never suggested that Katz lacked an understanding of these arrangements or that other adjudicative facts bearing on his interpretation of the Act should have been adduced. What plaintiffs apparently wished to present at a hearing were

legislative facts, such as the role of corporate or group practices in assuring high-quality emergency-room care in all hospitals. As I noted earlier, however, an evidentiary hearing need only be provided where adjudicative facts are at issue. Thus, due process certainly did not require such a hearing in this case.

Where legislative facts are at issue, though, due process may require some procedures short of an evidentiary hearing. *See FCC v. WJR, The Goodwill Station, Inc.*, 337 U.S. 265, 267, 271-77 (1949). Thus, it is possible that plaintiffs were denied due process here, even though they were not entitled to an evidentiary hearing. A review of the record, however, leads me to conclude that plaintiffs were afforded sufficient procedural protection to satisfy the demands of due process in this context.

As I noted earlier, the initial determination by Pennsylvania Blue Shield that NEMA did not employ the emergency-room physicians was based in large part on information supplied by NEMA. In November of 1978, plaintiff Caskey was advised that Pennsylvania Blue Shield would terminate the NEMA reassignment accounts for this very reason. Plaintiffs conceded the lack of an employer-employee relationship, but their attorney wrote to defendant Katz on January 2, 1979 and argued that the NEMA accounts were nevertheless proper because NEMA was a person providing services, within the meaning of section 1842(b)(5). Katz replied by letter dated February 2, 1979, stating (apparently on behalf of the Medicare Bureau) that NEMA was *not* a person providing services within that provision. In his letter, which I quoted earlier in this opinion, Katz explained this interpretation by reference to (1) the overall scheme of the Medicare statute, and (2) the relative recency of medical professional corporations. Plaintiffs filed this complaint on February 13. Pennsylvania Blue Shield wrote to plaintiff Caskey on February 14, advising him that the reassignment accounts would be terminated on February 22, although in fact they were not terminated until March 26.

Thus, plaintiffs received prior notice of the termination and a statement of reasons from Pennsylvania Blue Shield. Through counsel, plaintiffs then submitted written arguments to defendant Katz in support of their position that the reassignment accounts were proper under their interpretation of the Act. In response, plaintiffs received another statement of reasons—legal reasons, this time—why the accounts would be terminated. All this took place well before the termination occurred. True, plaintiffs developed further arguments, based on legislative facts, suggesting that the Medicare Bureau had misinterpreted the law by finding that NEMA was not a person providing services. (Those arguments are set forth in plaintiff's memorandum of law.) These arguments were never presented to defendants. But nothing in the record suggests that defendants in any way discouraged their submission. Although defendant Katz noted in his letter that the Act gave plaintiffs no right of appeal to the Secretary, plaintiffs' counsel presumably could have submitted additional written materials to defendant Katz in an effort to persuade him (and the Medicare Bureau) that he had misinterpreted the statute. Instead, counsel filed this complaint on February 13, 1979.

In short, proceeding on the assumption that plaintiffs were deprived of a "property" interest when the NEMA accounts were terminated, and bearing

in mind that plaintiffs sought additional opportunities to present *legislative* facts, I cannot say that they were denied any procedural protection required in this context as a matter of due process. The procedures employed here were unquestionably somewhat informal, but that does not make them constitutionally deficient. *Cf., e.g., Goss v. Lopez,* 419 U.S. 565, 584 (1975) (due process requires "at least an informal give-and-take between student and disciplinarian" in connection with brief suspension from school). The most noteworthy omission here—the lack of opportunity for oral argument—did not prevent plaintiffs from effectively presenting their position. Thus, I simply cannot say that plaintiffs were denied procedural due process here. *See, e.g., Mathews v. Eldridge,* 424 U.S. 319, 349 (1976) (due process requires only procedures "tailored, in light of the decision to be made, to 'the capacities and circumstances of those who are to be heard,' to insure that they are given a meaningful opportunity to present their case") (quoting *Goldberg v. Kelly,* 397 U.S. 254, 268-69 (1970)).

In view of my conclusions (1) that plaintiffs had no "property" interest in their asserted right to receive reassigned benefits, and (2) that, in any event, plaintiffs were not denied procedural due process when the reassignment accounts were terminated without more extensive procedures, I find that defendants are entitled to summary judgment in their favor on plaintiffs' constitutional claim.

SECTION 1861(s) (42 U.S.C. 1395x(s))—SUPPLEMENTARY MEDICAL INSURANCE—PAYMENT OF BENEFITS FOR OPTOMETRIC SERVICES

42 CFR 405.232 HCFAR 79-66c

Pushkin et al. v. Califano, U.S.C.A., 5th Circuit, 600 F.2d 486 (8/8/79)

Part B of Medicare reimburses a patient of a doctor of medicine for an eye examination for the purpose of establishing the necessity for prosthetic lenses. A patient may not be reimbursed for any examination performed by an optometrist, although the prescription or order of a doctor of optometry will be accepted as evidence of the medical need for prosthetic lenses (42 CFR 405.232c). *Held,* as plaintiff failed to prove that Congress acted irrationally in distinguishing between the diagnostic services provided by optometrist and doctors of medicine for the purposes of Medicare reimbursement, this regulation meets constitutional requirements.

CLARK, CIRCUIT JUDGE:

* * * * *

I.

Several licensed optometrists initiated this action in federal district court for injunctive and declaratory relief in a constitutional challenge to that part of the Medicare Act, 42 U.S.C.A. § 1395x(r), which for most purposes excludes doctors of optometry from the definition of "physician" under the Medicare Part B Health Insurance Program. Part B of the Medicare Act,

42 U.S.C.A. § 1395j–1395w, is a voluntary health insurance program in which a qualifying individual who obtains a covered service can either pay for the service and request reimbursement or assign the right of reimbursement to the person providing the service.[1] Functions covered by Part B are limited to certain "medical and other health services," 42 U.S.CA. § 1395k, which include "physician's services," 42 U.S.C.A. § 1395x(s)(1); that is, professional services performed by "physicians." 42 U.S.C.A. § 1395x(q).

Section 1395x(r), the section of Part B of the Act challenged by plaintiffs, defines the term "physician" in certain enumerated categories including

> (1) a [licensed] doctor of medicine or osteopathy . . ., (4) a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to establishing the necessity for prosthetic lenses.

To the extent the statutory definition of "physicians" limits its inclusion of the plaintiff-optometrists, their patients cannot be reimbursed or assign the right of reimbursement for optometric services. Plaintiffs argue that doctors of medicine or osteopathy, whose qualifying patients are always entitled to reimbursement, may perform many of the identical diagnostic services performed by doctors of optometry. Yet unless the optometric services are for the purpose of establishing the necessity for prosthetic lenses, their patients cannot receive Part B reimbursement. This overlap of services, plaintiffs say, makes the statutory classification excluding their patients from the benefits of the Act arbitrary, irrational, and not justified by any governmental interest. Thus, they claim that § 1395x(r) violates their right to equal protection under the fifth amendment.

Alternatively, plaintiffs challenge the validity of a regulation, 42 C.F.R. § 405.232c, promulgated by the Secretary to implement § 1395x(r), which states:

> The prescription or order of a doctor of optometry will be accepted as evidence of the medical need for prosthetic lenses. However, optometric examinations for any purpose are not covered.

They ask that the regulation be declared void because it cannot be reconciled with the definition of "physician" in § 1395x(r)(4) as written.

* * * * *

The gist of plaintiffs' constitutional claim is that the congressional decision to allocate Medicare funds by classifying the type of "physician" who renders the service is irrational because it fails to account for overlaps of services performed by different classes of doctors. Plaintiffs agree, however,

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[1] The Act consists of two complementary, separately financed programs. The basic plan in Part A provides protection against the costs of hospital and related post-hospital services, without charge, to qualifying elderly or disabled persons. 42 U.S.C.A. §§ 1395c, 1395d. Part B is a supplemental voluntary program of insurance which relies on the payment of periodic premiums to a trust fund which is used to defray beneficiaries' costs of physicians and other medical and health services. 42 U.S.C.A. §§ 1395j, 1395k.

that the classification is constitutional if it is rationally related to furthering a legitimate state interest.

> This inquiry employs a relatively relaxed standard reflecting the Court's awareness that the drawing of lines that create distinctions is peculiarly a legislative task and an unavoidable one. Perfection in making the necessary classifications is neither possible nor necessary. . . . Such action by the legislature is presumed to be valid.

Massachusetts Board of Retirement v. Murgra, 427 U.S. 307, 314, 96 S.Ct. 2562, 2567, 49 L.Ed.2d 520 (1976); *Dandridge v. Williams,* 397 U.S. 471, 90 S.Ct. 1153, 25 L.Ed.2d 491 (1976). Our power to overturn a statute, where fundamental interests or suspect groups are absent, is limited to the situation in which "the varying treatment of different groups or persons is so unrelated to the achievement of any combination of legitimate purposes that we can only conclude that the legislature's actions were irrational. *Barry v. Barchi,* —— U.S. ——, ——, 99 S.C. 2642, 60 L.Ed.2d —— (1979) *quoting, Vance v. Bradley,* —— U.S. ——, ——, 99 S.Ct. 939, 59 L.Ed.2d 171 (1979). Accordingly, plaintiffs would raise a substantial constitutional claim only if they could show that Congress, in distinguishing between the diagnostic services provided by optometrists and doctors of medicine for the purposes of Medicare reimbursement, acted irrationally. *Rastetter v. Weinberger,* 379 F.Supp. 170, 173 (D.Ariz. 1974), *aff'd,* 419 U.S. 1098, 95 S.Ct. 767, 42 L.Ed.2d 795 (1975).

Before enacting the Social Security amendments of 1967. Congress requested the Secretary of Health, Education and Welfare to conduct a study of the desirability of extending the use of Part B Medicare funds for services of additional types of licensed health practitioners. With the help of input from the affected health professions, the Secretary's comprehensive study concluded with a recommendation that, although there may be some overlap of diagnostic procedures of optometrists and ophthalmologists, their training was sufficiently different to indicate that the funds of the Part B program could best be used by limiting reimbursement to optometrists. HEW, Independent Practitioners Under Medicare: A Report to the Congress, at 114–22 (1968). In the face of this conscientious effort to maximize Medicare's coverage for the various healing professions, it cannot be said that Congress acted irrationally in providing reimbursement distinctions between the diagnostic services provided by a medical doctor and those provided by an optometrist. The failure to provide equal benefits to every conceivable interest in enacting reform legislation does not violate the equal protection clause. *Rastetter v. Weinberger, supra,* 379 F.Supp. 170. Plaintiff's constitutional issue is clearly an insubstantial one.

PART II, CUMULATIVE LISTING OF SELECTED COURT DECISIONS PUBLISHED AS RULINGS

79-D4—Limitations on coverage of costs. (4/13/79)

79-D6—Interest expense—necessary; Offset of interest expense by investment income. (4/27/79)

79-D8—Jurisdiction; Physical Therapy Salary Equivalency Guides; Validity. (4/27/79)

79-D11—Purchase of stock v. purchase of asset; Return on equity capital; Interest expense. (5/11/79)

79-D14—Method of allocating costs—skilled nursing facility. (5/12/79)

79-D15—Limitations on coverage of costs. (5/16/79)

79-D17—Cafeteria and snack bar costs. (5/31/79)

79-D18—Joint education activities. (5/23/79)

79-D19—Joint educational activities. (5/23/79)

79-D20—Limitations on coverage of costs. (6/8/79)

79-D21—Costs of utilization review; Admissions Department costs; Legal fees. (6/11/79)

79-D24—Rental payments; Special care units. (7/3/79)

79-D27—Substantiation requirements; Management fees. (7/19/79)

79-D28—Special care units. (7/21/79)

79-D29—Limitation on coverage of costs—Classification of provider as SMSA. (7/21/79)

79-D31—Purchase of stock v. purchase of assets; Stock maintenance costs. (7/30/79)
Note: Decision withdrawn by Administrator's Order. (8/16/79)

79-D32—Physician-owners' compensation; Related organizations. (8/10/79)

79-D34—Utilization review costs. (8/17/79)

79-D41—Patient telephone services; Reopening of prior years' cost reports. (9/6/79)

79-D42—Patient telephone services; Reopening of prior years' cost reports. (9/16/79)

79-D43—Patient telephone services; Reopening of prior years' cost reports. (9/6/79)

79-D44—Limitation on coverage of costs—Classification of provider as non-SMSA. (9/14/79)

77-D32R—Reasonableness of salaries of pensions. (12/10/79)

79-D50—Costs of utilization review. (10/4/79)

79-D52—Purchase of stock v. purchase of assets; Return on equity capital; Goodwill. (10/15/79)

79-D55—Leased hospital department to hospital-based physicians; Offset of excess rental income. (10/26/79)

79-D56—Interest expense. (11/5/79)

79-D60—Legal fees. (12/10/79)

79-D62—Interest expense; Amortization of deferred financing. (12/4/79)

79-D64—Vested sick leave. (12/10/79)

79-D65—Limitation on coverage of costs; Physical Therapy Salary Equivalency Guides; Validity. (12/10/79)

79-D70—Special care units. (12/10/79)

Numeric Index of the Administrator Health Care Financing Administration Decisions to Remand PRRB Decisions

78-D9—Remanded by Order of the Administrator for further administrative action pursuant to Court's Order. (9/18/79)

78-D46—Remanded by Order of the Administrator for further administrative action pursuant to Court's Order. (9/11/79)

79-D81—Remanded by Order of the Deputy Administrator for decisive decision by PRRB. (12/21/79)

PART IV, Listings of Published Health Care Financing Administration Program Regulations April–December 1979

The following amendments and additions to HCFA regulations have been published in the *Federal Register*:

1. 42 CFR Part 447—Payments for Services; Public Notice of Changes in Method or Level of Reimbursement (44 FR 20693, April 6, 1979)

2. Notice—Pharmaceutical Reimbursement Board; Proposed MAC's and Announcement of Public Hearing (44 FR 21367, April 10, 1979)

3. Notice—Statewide Professional Standards Review Council of New York; Request for Nominations for Public Member Positions on the Council (44 FR 21893, April 12, 1979)

4. Notice—Statewide Professional Standards Review Council, Connecticut; Request for Nominations for Public Member Positions on the Council (44 FR 23319, April 19, 1979)

5. Notice—Statewide Professional Standards Review Council of Massachusetts; Request for Nominations for Public Member Positions on the Council (44 FR 23319, April 19, 1979)

6. Notice—Statewide Professional Standards Review Council of Pennsylvania; Request for Public Member Positions on the Council (44 FR 24637, April 26, 1979)

7. Notice—Request for Nominations for Public Member on Statewide Professional Standards Review Council of Maryland (44 FR 24638, April 26, 1979)

8. Notice—Correction of Error: MAC Limit on Penicillin G 400 mu Tablets (44 FR 24931, April 27, 1979)

9. Notice—PSRO Council meeting (44 FR 27264, May 9, 1979)

10. Notice—Final Maximum Allowable Cost Determinations (44 FR 28104, May 14, 1979)

11. 42 CFR Part 405—Requirements of the Contract between the Secretary and a Health Maintenance Organization under Medicare (44 FR 29058, May 18, 1979)

12. 42 CFR Part 441—Medicaid Requirements for State Programs of Early and Periodic Screening Diagnosis, and Treatment of Individuals Under 21 (44 FR 29420, May 18, 1979)

13. 42 CFR Part 435—Medicaid Eligibility: Timely Claims Processing (44 FR 30341, May 25, 1979)

14. 42 CFR Part 405—Medicare Program; Limiting Reimbursement for Provider Costs and for Services by Hospital-Based Physicians (44 FR 31802, June 1, 1979)

15. 42 CFR Part 405—Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians; Direct Apportionment of Malpractice Costs to Medicare (44 FR 31641, June 1, 1979)

16. Notice—Medicare Program; Schedule of Limits on Hospital Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or After July 1, 1979 (44 FR 31806, June 1, 1979)

17. Notice—Medicare Program; Initial Schedule of Limits on Home Health Agency Costs Per Visit for Cost Reporting Periods Beginning on or After July 1, 1979 (44 FR 31814, June 1, 1979)

18. 42 CFR Part 460—PSRO Hospital Review; Relationship of PSRO to Hospitals and Use of Hospital Review Committee; Norms for PSRO Hospital Review (44 FR 32074, June 4, 1979)

19. Notice—National Professional Standards Review Council; Notice of Cancellation (44 FR 37335, June 26, 1979)

20. 42 CFR 460—Redesignation of Professional Standards Review Organizations Areas in North Carolina (44 FR 37507, June 27, 1979)

21. 42 CFR Subchapter C—Medical Assistance Program—Medicaid Regulations—Reorganization and Rewriting of Regulations; Correction (44 FR 37610, June 28, 1979)

22. Notice—Pharmaceutical Reimbursement Board; Suspension of Maximum Allowable Cost Limits (44 FR 37690, June 28, 1979)

23. Notice—Medicare Program; Economic Index for Physicians' Services for the Period July 1979 Through June 30, 1980 (44 FR 37977, June 29, 1979)

24. 42 CFR Part 405—Medicare Program; Elimination of the Combination Method of Apportionment and Modified Costs Finding for Providers; Correction (44 FR 40506, July 11, 1979)

25. Notice—Statement of Organization, Functions, and Delegations of Authority: HCFA (44 FR 41331, July 16, 1979)

26. 42 CFR Part 420—Medicare and Medicaid Providers; Disclosure of Information and Access to Provider Records; Requirements and Conditions for Participation (44 FR 41636, July 17, 1979)

27. 42 CFR Part 460—Eligibility in the States, the District of Columbia and Guam, Puerto Rico, and the Virgin Islands; State Residence Requirements (44 FR 41434, July 17, 1979)

28. Notice—Medicare Program; Schedule of Limits on Hospital Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or After July 1, 1979; Correction (44 FR 43109, July 23, 1979)

29. Notice—Statement of Organization, Functions, and Delegations of Authority; OMB (44 FR 46533, August 8, 1979)

30. Notice—Pharmaceutical Reimbursement Board; Final Maximum Allowable Cost Determinations (44 FR 50651, August 29, 1979)

31. Notice—Medicare and Medicaid Programs; Schedule of Limits on Skilled Nursing Facility Inpatient Routine Service Costs (44 FR 51542, August 31, 1979)

32. Notice—Medicare and Medicaid Programs; Schedule of Limits on Skilled Nursing Facility Inpatient Routine Service Costs—Correction (44 FR 53314, September 13, 1979)

33. Notice—Change of Designation of Chairman of the Pharmaceutical Reimbursement Board (44 FR 55877, September 28, 1979)

34. 42 CFR Part 456—Medical Assistance Program; Penalty for Failure to Make a Satisfactory Showing of an Effective Institutional Utilization Control Program (44 FR 56333, October 1, 1979)

35. Notice—Position Statement on Access to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services Through Schools (44 FR 57222, October 4, 1979)

36. Notice—Privacy Act of 1974—Systems of Records; Annual Publication (44 FR 58229, October 9, 1979)

37. Notice—Privacy Act of 1974; Systems of Records and Notice of Proposed Routine Uses; Health Maintenance Organization Prospective Reimbursement Demonstrations and Municipal Health Services Program (2 documents) (44 FR 58808, October 11, 1979)

38. 42 CFR Part 405—Federal Health Insurance for the Aged and Disabled; Target Rate Reimbursement for Institutions Furnishing Home Dialysis Supplies, Equipment, and Support Services (44 FR 60287, October 19, 1979)

39. Notice—Medicare Program; Schedule of Target Reimbursement Rates for Institutions Furnishing Home Dialysis Supplies, Equipment, and Support Services (44 FR 60412, October 19, 1979)

40. Notice—National Professional Standards Review Council; Meeting (44 FR 60414, October 19, 1979)

41. 42 CFR Part 447—Medicaid; Abortions (44 FR 61598, October 26, 1979)

42. 42 CFR Part 405—Medicare Program; Payment for Inpatient Services of Foreign Hospitals (44 FR 67381, November 26, 1979)

43. 42 CFR Part 405—Medicare Program; Beneficiary Liability for Certain Non-reimbursable Services or Items (44 FR 68466, November 29, 1979)

44. Notice—Medicare Program; Premium Rate for the Uninsured Aged (44 FR 74164, December 17, 1979)

45. Notice—Statement of Organization, Functions, and Delegations of Authority (44 FR 75719, December 21, 1979)

46. Notice—Monthly Adequate Actuarial Rates and Monthly Premium Rates (44 FR 77264, December 31, 1979)

PART V, HEALTH CARE FINANCING ADMINISTRATION INDEX OF ADMINISTRATIVE MANUALS AND INSTRUCTIONS

The Freedom of Information Act, as amended (Public Law 93–502) requires each government agency to make available for public inspection and copying all administrative manuals and instructions to staff which affect any member of the public. In order to give the public an understanding of what material is thereby available, agencies must provide a regularly updated index of pertinent titles. This index itself, like the manuals and other materials it lists, is required by law to be available to the public for inspection and copying upon request.

The following Index represents an update of instructions and other issuances from April 1979 through December 1979. For the cumulative listing of instructions and other issuances issued before April 1979, see the *Health Care Financing Administration Rulings,* MBR-3 (April 1979).

The Index will be maintained in all Health Care Financing Adminstration Regional Offices where it may be examined by members of the public. The office will supply photocopies of selected pages upon request. (There may be a fee charged for this service, depending on the quantity of material requested.)

Any questions regarding this index should be made in writing to:

HCFA
Bureau of Program Policy
6401 Security Blvd.
Baltimore, Maryland 21235

MEDICAID

ACTION TRANSMITTALS

The Action Transmittals are designed to transmit policies of the Medicaid program to individuals who participate and administer the program. A numeric listing of the Action Transmittals issued from April through December 1979 follows:

AT–79–28 —Fiscal Disallowance for Erroneous Payments

AT–79–29 —Redesignation and Rewrite—Medicaid

AT–79–30 —Proposed List of Additional Items & Services Subject to the Lowest Charge Level

AT–79–31 —FFP in State Claims for Sterilizations—Answers to Questions

AT–79–32 —Lowest Charge Level for Medical Services Supplies, and Equipment.

AT–79–33 —Correction: MMB Medical Assistance Manual Personal Care Services in Recipient's Home

AT–79–34 —Six Month Claims Collection Procedure for Medicaid Quality Control

AT–79–35 —State Assistance Expenditures—Promulgation of Federal Percentages and Federal Medical Assistance Percentages

AT–79–36 —Monthly Statistical Report on Medical Care: Form HCFA–120

AT–79–37 —Public Notice of Changes in Method or Level of Reimbursement

AT–79–38 —Preprinted State Plan Amendment on Public Notice of Changes in Method or Level of Reimbursement

AT–79–39 —Preprinted State Plan Amendments on Appeals Proceedings for Denial, Termination, or Nonrenewal of Certifications and Provider Agreements

AT–79–40 —Proposed Initial Schedule of Limits on Home Health Agency Costs per Visit for Reporting Periods Beginning June 1, 1979

AT–79–41 —Medical Assistance Program; Reasonable Cost-Related Reimbursement for Skilled Nursing and Intermediate Care Facilities

AT–79–42 —Title XIX, Social Security Act: Preprinted State Plan Amendment on Prohibited Activities

AT–79–43 —Title XIX, Social Security Act, Federal Funding of Abortions

AT–79–44 —Revisions to Edits in MQC Reports Manual Section 4000, Appendix A.

AT–79–45 —EPSDT Penalty Revisions

AT–79–46 —Extension of Reporting Requirements for Quarterly Statements of Financial Plan (OA–25A and OA–25.5)

AT–79–47 —Limitation on Payment or Reimbursement for Drugs

AT–79–48 —MMIS Regulation

AT–79–49 —Hearing Aids and Eyeglasses

AT–79–50 —Timely Claims Processing

AT–79–51 —Practictioners, Providers, or Other Health Care Suppliers Suspended, Excluded, or Terminated from the Medicare and Medicaid Programs

AT–79–52 —Court Order Affecting Deeming Policies in 209(b) States, Guam, P.R. and V.I.

AT–79–53 —Schedule of Limits on Skilled Nursing Facility Inpatient Routine Service Costs for Cost Reporting Periods Beginning on or After October 1, 1979

AT–79–54 —Suspension of Practitioners

AT–79–55 —Timely Claims Payment

AT–79–56 —Revision in the Medicaid QC Training Guide

AT–79–57 —Direct Apportionment of Malpractice

AT–79–58 —Address Change, MEDICAID Program Data Branch

AT–79–59 —Initial Schedule of Limits on Home Health Agency Costs that may be Reimbursed under Medicare

AT–79–60 —Reorganization of the Health Care Financing Administration

AT–79–61 —Utilization Control: Format of Quarterly Showings

AT–79–62 —Title XIX, SSA, § 1903(g) Utilization Control (UC) Validation Survey for the Quarter ending June 30, 1979, in 10 Selected States' Mental Hospitals (MHs). These States are Massachusetts, New Jersey, Pennsylvania, Florida, Ohio, Louisiana, Missouri, Colorado, California and Oregon

AT–79–63 —Change in Reporting of Sterilizations and Hysterectomies: Form HCFA/OHDS–80

AT–79–64 —Title XIX, Social Security Act: Preprinted State Plan Amendment on Suspension of Practitioners Convicted of Crimes Related to Medicare or Medicaid

AT–79–65 —Title XIX, Social Security Act: State Residence Requirements

AT–79–66 —Additional Extension of Reporting Requirements for Quarterly Statements of Financial Plan (OA–25A and OA–25.5)

AT–79–67 —Medicaid QC Policy on Review of SSI–QA Drops in Non-1634

AT–79–68 —Identification of Medicaid Quality Control Sample Cases

AT–79–69 —Medicaid Requirements for State Program of Early & Periodic Screening, Diagnosis & Treatment of Individuals under 21—Policy Interpretation—Program & Penalty Provisions.

AT–79–70 —Title XIX, SSA: PSRO Hosp. Review: Relationship of PSRO to Hospitals & Use of Hosp. Review Committees, Norms for PSRO Hosp. Review

AT–79–71 —Title XIX, Social Security Act: Preprinted State Plan Amendment on Early & Periodic Screening, Diagnosis & Treatment

AT–79–72 —Title XIX, Social Security Act: Implementation of Supreme Court Decision in Califano vs. Westcott AFDC

AT–79–73 —Title XIX, Social Security Act: Preprinted State Plan Amendment on Unemployed Parents

AT–79–74 —Title XVIII and XIX, Disclosure of Information and Access to Provider Records; Requirements & Conditions for Participation

AT–79–75 —Title XIX, SSA: Preprinted State Plan Amendment on State Residence requirements.

AT–79–76 —Implementation of New Federal Reporting Requirements for Medicaid

AT–79–77 —Preprinted State Plan Amendments on (1) required provider agreements, (2) disclosure of survey information

AT–79–78 —Revision of Complete Text of Preprinted State Plan

AT–79–79 —Practitioners, Providers, or Other Health Care Suppliers Suspended, Excluded, or Terminated from the Medicare and Medicaid Programs

AT–79–80 —Practitioners, Providers, or Other Health Care Suppliers Suspended, Excluded, or Terminated from the Medicare and Medicaid Programs

AT–79–81 —Medicaid Quality Control (MQC) Review for State Buy-in and Medicare Part B Coordination Error Conditions

AT–79–82 —Revision to Edits and Reporting Table Instructions for Medicaid Quality Control Manual—Section 4000

AT–79–83 —Federal Requirements under Medicaid for the Provision of Family Planning Services.

AT–79–84 —Consistency Between State Eligibility Case Findings and State Payment Findings; Changing Case Findings Based on SSI–QA Revisions

AT–79–85 —Medicaid Quality Control Instructions for Reviewing and Citing Dollar and Non-Dollar Errors in the Claims Processing Review

AT–79–86 —Limitation on Payment or Reimbursement for Drugs

AT–79–87 —Quality Control System Error Rate

AT–79–88 —Title XIX, Social Security Act; Final Schedule of Limits on SNF Inpatient Routine Service Costs

AT–79–89 —Title XIX, Social Security Act: Correction to Preprinted State Plan Amendments on Three Items

AT–79–90 —Practitioners, Providers, or Other Health Care Suppliers Suspended, Excluded, or Terminated from the Medicare and Medicaid Programs

AT–79–91 —Practitioners, Providers, or Other Health Care Suppliers Suspended, Excluded, or Terminated from the Medicare and Medicaid Programs

AT–79–92 —Revised Requirements for Completing the Medicaid Quality Control Forms

AT–79–93 —Special Review of State Estimates and Additional Extension of Reporting Requirements for Quarterly Statements of Financial Plan (OA–25.5 and OA–25A)

AT–79–94 —MQC Review of Claims with Service Dates that Span More Than One Month

AT–79–95 —Length of the Paid Claims History File Required for the Medicaid Quality Control (MQC) Claims Processing Review

AT–79–96 —Medicaid Quality Control (MQC) Claims Processing Review of Medicare Crossover Claims

AT–79–97 —Adjustment of State Claims for Federal Financial Participation (FFP) to Exclude Payments Resulting from Third Party Liability and Claims Processing Errors

AT–79–98 —Title XIX Social Security Act: Federal Funding of Spontaneous Abortions

AT–79–99 —Definition—For Agency Type Error of "Reported Information Inaccurate"

AT–79–100 —Medicaid Quality Control (MQC) Review of Health Maintenance Organizations (HMOs)

AT–79–101 —MAM: State Organization; Staffing for Administration; Federal Financial Participation; Implementation; Staff of Other Public Agencies

AT–79–102 —Penalty for Failure to Make a Satisfactory Showing of an Effective Institutional Utilization Control Program

AT–79–103 —Practitioners, Providers, or Other Health Care Suppliers, Suspended, Excluded, or Terminated from the Medicare and Medicaid Programs

AT–79–104 —Federal Funding of Abortions

AT–79–105 —Worksheets required by Medicaid Quality Control (MQC) for AFDC–QC and SSI–QA eligible cases

AT–79–106 —Deeming of Income in 209(b) States and Territories

AT–79–107 —Format/Reporting Requirements for Submitting MQC Data Tapes

AT–79–108 —Practitioners, Providers, or Other Health Care Suppliers Suspended, Excluded, or Terminated from the Medicare and Medicaid programs

AT–79–109 —Coding of Item H on the Medicaid Quality Control (MQC) Review Schedule

AT–79–110 —Sampled Beneficiaries with More than One Open Medicaid Case

AT–79–111 —Change of Mailing Address

AT–79–112 —Addenda to Instructions for Completion of Revised Forms HCFA–120 and HCFA–2082

Information Memoranda

The Information Memoranda are policy instructions and other informational material as deemed necessary to Medicaid program participants regarding certain aspects of the program that should be emphasized and elaborated upon because of problems which have been pointed out. A numeric listing of the Information Memoranda issued from April through December 1979 follows:

HCFA–IM–79–17 —Peer Review Support for the Office of Program Integrity, HCFA; Medicare Carriers and Intermediaries; and Single State Agencies

HCFA–IM–79–18 —Transfer of Oversight Responsibility for State Medicaid Fraud Control Units

HCFA–IM–79–19 —Zip Sort Mail for Postage Discounts

HCFA–IM–79–20 —Directory of Issuances—Medicaid Program

HCFA–IM–79–21 —Medicaid Quality Control Reporting

HCFA–IM–79–22 —State Legislative Committees with Jurisdiction over Medicaid

HCFA–IM–79–23 —Session on New EPSDT REGULATIONS

HCFA–IM–79–24 —State Agency Personnel Directors' Workshop—June 26–29

HCFA–IM–79–25 —Third Party Benefit Recovery Program

HCFA–IM–79–26 —EPSDT Program Information

HCFA–IM–79–27 —Review of Physician Services Delivered During Medicare and Medicaid Beneficiaries' Hospitalizations

HCFA–IM–79–28 —Definition of a Claim for Medicaid Quality Control Purposes

HCFA–IM–79–29 —Common Audit of Hospitals through Exchange of Information

HCFA–IM–79–31 —Seminar on Cost-Related Reimbursement for Long Term Care, September 18–20, 1979, Los Angeles, California

HCFA–IM–79–32 —Mid-Year Conference of State Medicaid Directors

HCFA–IM–79–33 —Supplemental Security Income (SSI) and Retirement, Survivors' and Disability Insurance (RSDI) Benefit Increases

HCFA–IM–79–34 —Revision of Policy on ICD–9–CM

HCFA–IM–79–35 —Failure to Complete July–September 1978 Review Period

HCFA–IM–79–36 —Mid-Year Conference of State Medicaid Directors November 14–16, 1979, Orlando, Florida

HCFA–IM–79–37 —List of Single State Agency Directors and Medical Assistance Unit Directors

HCFA–IM–79–38 —Data on the Medicaid Program, 10/79 Edition

HCFA–IM–79–39 —Workshop on Management Information for Medicaid

HCFA–IM–79–40 —Availability of Technical Assistance to State Medicaid Agencies through the Corrective Action Projects Division

HCFA–IM–79–41 —Medicare Policy Clarification on Coverage of Hospital Admission Diagnostic Procedures

HCFA–IM–79–42 —Role of the Office of Systems Analysis (OSA), Bureau of Quality Control, HCFA

REGIONAL OFFICE MANUAL ISSUANCES

Manual

The Regional Office Manual (ROM) is the primary vehicle for policy and other program issuances to the Regional Offices. The manual is in looseleaf form to allow for easy addition, deletion and correction. It contains policy information explaining and clarifying material in the regulations. The or-

ganization of the major portion of the manual to conform to the arrangement of the Code of Federal Regulations will make it easier to use and to incorporate currently existing issuances (in particular PIQs) into the new system. A numeric listing of these Medicaid ROM-Issuances issued from April through December 1979 follows:

ROM 3 —General requirements: State Plan Approval—Eligibility (04/25/79)

ROM 4 —Individuals Who Would Be Eligible for, but Are Not Receiving Cash Assistance, Application for SSI Benefits as a Condition of Medicaid Eligibility (04/25/79)

ROM 5 —Administration: Participation Requirements for EPSDT Providers, Clarification of State Responsibilities (05/04/79)

ROM 6 —Determinations of Disability, HCFA Policy Regarding Medicaid Eligibility of Individuals Who Die Before a Determination Can Be Made (05/10/79)

ROM 7 —Citizenship and Alienage: Unborn Children. HCFA Policy Regarding Medicaid Eligibility for Unborn children when the Mother Does *Not* Meet Citizenship/Alienage Requirements (05/10/79)

ROM 8 —Conversion List for Policy Interpretation Questions to the HCFA Regional Office Manual. These Reissuances Supersede Policy Interpretation Questions MMB–PIQ–78–1, January 17, 1978, through MMB–PIQ–79–1, November 24, 1979 (the last MMB–PIQ issued) (05/21/79)

ROM 9 —Cross Reference Sheets for Regional Office Manual Issuances Converting Policy Interpretations MMB–PIQ–78–1 Through MMB–PIQ–79–1 (05/21/79)

ROM 10 —State Organization and General Administration. Reissuance of Policy Interpretation Question MMB–PIQ–79–1 (05/21/79)

ROM 11 —State Organization and General Administration. Reissuance of Policy Interpretation Questions MMB–PIQ–78–12, 78–22, 78–24, and 78–27 (05/21/79)

ROM 12 —State Personnel Administration. Reissuance of Policy Interpretation Questions MMB–PIQ–78–21, 78–23, and 78–26 (05/21/79)

ROM 13 —State Fiscal Administration. Reissuance of Policy Interpretation Question MMB–PIQ–78–20 (05/21/79)

ROM 14 —Eligibility in the States and District of Columbia. Reissuance of Policy Interpretation Questions MMB–PIQ–78–5, 78–11, 78–13, 78–15, 78–16, and 78–19 (05/21/79)

ROM 15 —Eligibility in the States and District of Columbia. Reissuance of Policy Interpretation Questions MMB–PIQ–78–1, 78–2, 78–7, and 78–17 (05/21/79)

ROM 16 —Payment for Services. Reissuance of Policy Interpretation Questions MMB–PIQ–78–3, 78–4, 78–8, 78–9, 78–25 and 78–28 (05/21/79)

ROM 17 —Foreward and Table of Contents for Part 6, Medicaid, of HCFA Regional Office Manual (05/21/79)

ROM 18 —Maintaining Services, Recoupment of Assistance Extended During Appeal Process (06/07/79)

ROM 19 —State Agency Third Party Liability Recovery Authority and Responsibility in Relation to the Life Time Reserve Days of Joint Medicare-Medicaid Eligibles: Clarification of the Policy with Regard to Utilization of the Hospital Life Time Reserve Days by a Medicare/Medicaid Eligible Recipient (06/07/79)

ROM 20 —Conversion list of Policy Interpretation Questions to the HCFA Regional Office Manual (06/15/79)

ROM 21 —Chapter 2—State Organization and General Administration. Reissuance of Policy Interpretation Question MMB–PIQ–77–3 (06/15/79)

ROM 22 —Chapter 3—State Personnel Administration. Reissuance of Policy Interpretation Question MMB–PIQ–77–9 (06/15/79)

ROM 23 —Chapter 5—Eligibility in the States and District of Columbia. Reissuance of Policy Interpretation Questions MMB–PIQ–77–4, 77–6, 77–10, 77–11, and 77–12 (06/15/79)

ROM 24 —Chapter 7—Services: General Provisions. Reissuance of Policy Interpretation Questions MMB–PIQ–77–1, 77–2, 77–5, and 77–13 (06/15/79)

ROM 25 —Chapter 8—Services: Requirements and Limits Applicable to Specific Services. Reissuance of Policy Interpretation Question MMB–PIQ–77–8 (06/15/79)

ROM 26 —Chapter 10—Payments for Services. Reissuance of Policy Interpretation Questions MMB–PIQ–77–7, 77–14, and 77–15 (06/15/79)

ROM 27 —Cross Reference Sheets for Regional Office Manual Issuances Converting Policy Interpretation Questions MMB-PIQ-77-1 Through MMB-PIQ-77-15 (06/15/79)

ROM 28 —Conversion List of Policy Interpretation Questions to the HCFA Regional Office Manual. These Reissuances Supersede all MSA Policy Interpretation Questions PIQ-77-1 Through PIQ-77-81 and Supersede PIQs 77-11, 77-68, and 77-75 Only as They Relate to Medicaid (06/19/79)

ROM 29 —Chapter 1—Grants to States for Medical Assistance Programs. Reissuance of Policy Interpretation Question PIQ-77-11 (06/19/79)

ROM 30 —Chapter 2—State Organization and General Administration. Reissuance of Policy Interpretation Questions PIQ-77-47, 77-50, 77-55, 77-68, 77-75 and 77-81 (06/19/79)

ROM 31 —Chapter 5—Eligibility in the States and District of Columbia. Reissuance of Policy Interpretation Questions PIQ-77-6, 77-12, 77-13, 77-14, 77-23, 77-28, 77-34, 77-35, 77-45, 77-49, 77-56, 77-62, 77-63, 77-67 and 77-77 (06/19/79)

ROM 32 —Chapter 7—Services: General Provisions. Reissuance of Policy Interpretation Questions PIQ-77-29, 77-70 and 77-74 (06/19/79)

ROM 33 —Chapter 8—Services: Requirements and Limits Applicable to Specific Services. Reissuance of Policy Interpretation Questions PIQ-77-61 and 77-69 (06/19/79)

ROM 34 —Chapter 9—Standards for Payment for Skilled Nursing and Intermediate Care Facility Services. Reissuance of Policy Interpretation Question PIQ-77-42 (06/19/79)

ROM 35 —Chapter 10—Payments for Services. Reissuance of Policy Interpretation Questions PIQ-77-33, 77-43 and 77-46 (06/19/79)

ROM 36 —Cross Reference Sheets for Regional Office Manual Issuances Converting Medicaid Issuances from Policy Interpretation Questions PIQ-77-1 Through PIQ-77-81 (06/19/79)

ROM 37 —Prohibitions on FFP: Institutionalized Individuals: Payment for Services to Residents of ICF/MRs when Health Services are Prescribed both by Medicaid Regulation and Education of the Handicapped Act (06/19/79)

ROM 38 —Institutionalized: Income Protected for Needs and Maintenance Amounts for Non-institutionalized Spouse and Family Protected from Income (06/19/79)

ROM 39 —§3677, Intermediate Care Facility Services, Other than in Institutions for Tuberculosis or Mental Diseases (11/07/79)

ROM 40 —Sec. 6500, Exclusion of Providers and Suspension of Practitioners. Impact of Criminal Fraud Conviction of Title XIX (11/20/79)

REGIONAL LETTER SERIES

The Medicaid Regional Letter (RL) Series conveys material which has limited or no retention value. The RL Series includes informational and instructional material such as copies of reports and one-time requests to investigate certain areas. A numeric listing of these RLs issued from April through December 1979 follows:

RL–79–25 —Action—MQC Negative Case Action Implementation Plans for the April-September 1979 Reporting Period (4/9/79)

RL–79–26 —Information—Selected Changes In State Medicaid Programs (4/9/79)

RL–79–27 —Information—Pooled Personal Needs for Group Purchases—SSA Medicaid Policy Conflict (4/9/79)

RL–79–28 —Action—Interagency Agreements (4/9/79)

RL–79–29 —Action—MQC Survey Planning for April-September 1979 (4/17/79)

RL–79–30 —Information—Dallas, Kansas City and Central Office Meeting —Questions and Answers (4/20/79)

RL–79–31 —Action—Third Party Liability Collection Reports for FY '79 (4/23/79)

RL–79–32 —Monthly Regional Report on Savings and Cost Avoidance (4/23/79)

RL–79–33 —Action—Medicaid State Assessment Manual (4/25/79)

RL–79–34 —Instructions for Reporting on the Fraud, Abuse and Waste Initiative 6: Installation and Operation of a Medicaid Management Information System—Action (4/25/79)

RL–79–35 —Guidelines For Federal Approvals and Periodic Reviews of State Medicaid Systems Operations—Action (4/25/79)

RL–79 36 —Third Party Liability Savings, MITS/FAW Initiative (5/8/79)

RL–79–37 —Conversion of Old Issuances to New Regional Office Issuance Systems (5/10/79)

RL–79–38 —Deeming of Income in 209(b) States, Guam, Puerto Rico, and The Virgin Islands (5/18/79)

RL–79–39 —Regional Office Prior Review of Subcontracts for Federally Qualified Health Maintenance Organizations (HMO) Participating Under the Medicaid Program (5/21/79)

RL–79–40 —MITS Status Report for MMIS Activities (5/30/79)

RL–79–41 —Follow-up Training Session on Medicaid Management Information System (MMIS) Tracking and Reporting (FAW Initiative #6) (5/30/79)

RL–79–42 —Sessions on New EPSDT Regulations (5/29/79)

RL–79–43 —State Profiles for EPSDT (6/7/79)

RL–79–44 —Information—Index of Action Transmittals which Affect Medicaid Quality Control (MQC) Manual Changes (6/7/79)

RL–79–45 —Information—EPSDT Statistical Reports Immunization Reporting through EPSDT (6/7/79)

RL–79–46 —Preventive Health Encounters and EPSDT—ACTION (6/8/79)

RL–79–47 —Pen-and-Ink Correction to State Plan (6/19/79)

RL–79–48 —Joint OHMO/HCFA Initiative to Increase Medicaid/HMO Contracts—ACTION (6/19/79)

RL–79–49 —Guidelines for Reporting Third Party Liability (TPL) Savings on HCFA–64.9a (Quarterly Schedule of Third Party Liability Collections for the Medical Assistance Program)—Information (6/19/79)

RL–79–50 —Abortion Reporting—ACTION (07/18/79)

RL–79–51 —Secretary's Initiative to Increase Medicaid HMO Contracts Effect of the Medicaid Quality Control (MQC) Disallowance (07/18/79)

RL–79–52 —Deeming of Income in 209(b) States, Guam, Puerto Rico, and the Virgin Islands (8/79)

RL–79–53 —Regulation on Adjustments to State Claims for Federal MQC Eligibility Payment Errors (7/30/79)

RL–79–54 —Medicaid Quality Control (MQC) Telephone Report Worksheet (7/30/79)

RL–79–55 —Request for Sample MMIS and Other State Program Reports —ACTION (8/08/79)

RL–79–56 —Information—Utilization Control (UC) Validation Survey for the Quarter Ending June 30, 1979 (8/15/79)

RL–79–57 —State Assessment & Annual Contractor Eval. Report Program (8/17/79)

RL–79–58 —Proposals for Advisory Groups Representing State Medicaid Agencies (8/27/79)

RL–79–59 —Regional Office Recommendations for Disapproval of State Plan Amendments (9/11/79)

RL–79–60 —Designation of Regional Office Liaison Person and Other Regional Office Actions to Aid in the Implementation of the New Medicaid Reporting Requirements—ACTION (10/10/79)

RL–79–61 —Revised Distribution List for State Management Review Reports (10/18/79)

RL–79–62 —Utilization Control: Instructions for Reviewing States' Qrtly. Showings Under § 1903(g) for the Quarter Ending 9/30/79 (10/18/79)

RL–79–63 —Abortion Reporting (10/23/79)

RL–79–64 —Change in State Plan Status Information Reporting—ACTION (11/05/79)

RL–79–65 —Selected Changes in State Medicaid Programs (11/07/79)

RL–79–66 —Maximus Study (12/05/79)

RL–79–67 —State Plan Amendment Status Report, June 30, 1979—INFORMATION (12/14/79)

RL–79–68 —Ranking of Medicaid State Agencies Based on Performance—ACTION (12/14/79)

RL–79–69 —Clarification of Monitoring Guide on Minimum Documentation Required in Medicaid Quality Control (MQC) Federal Re-review Case File (12/17/79)

RL–79–70 —Late Medicaid Quality Control Statistical Summary Report Table Submissions for July-September 1978—ACTION (12/31/79)

RL–79–71 —Revisions to the DATAMED System—INFORMATION (12/31/79)

RL–79–72 —Medicaid Requirements for Use of the Eligibility Form and Notice of Admission—ACTION (1/04/80)

HEALTH STANDARDS AND QUALITY BUREAU

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS TRANSMITTALS

The Professional Standards Review Organizations (PSRO) transmittals contain administrative, procedural, and policy instructions for use in administering the PSRO program. A numeric listing of these PSRO transmittals issued from April through December 1979 follows:

PSRO Transmittal No. 89 —Reduction of PSRO Hospital Review Costs (4/25/79)

PSRO Transmittal No. 90 —Revised Instructions for Preparation and Submission of PHDDS Tapes (Supplement to PSRO Transmittals No. 28 and No. 50) (5/79)

PSRO Transmittal No. 91 —Documentation of PSRO Review Determinations on Medicare Bills (10/24/79)

Department of Health
and Human Services
Health Care Financing Administration
Baltimore, Maryland 21235

Health Care Financing Administration Rulings